

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14043

14011

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S. Arlington</u> <u>83X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> <u>M</u> <u>Ailes</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1907</u> <u>54</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>54</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Alfred H. McLantire</u>	
14. MOTHER'S MAIDEN NAME <u>Clara Hudson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>162-1</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162-1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 27, 1961</u> to <u>Dec. 6, 1961</u> that (2) (we) last saw the deceased alive on <u>Dec. 6, 1961</u> , and that death occurred at <u>7:58 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. De Forest</u> M.D.		22b. DATE SIGNED <u>December 6, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT E. DE FOREST LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
25c. ADDRESS <u>Arlington Funeral Home, Arlington, Va.</u>		25d. DATE <u>DEC 8 '61</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1904

(M)

*Benjamin Franklin*

*Benjamin Franklin*

Any delay is necessary,  
the funeral director. Page  
obtained for your files.  
State Board of Health,  
death.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral home. If there is no funeral home, file them with the county health department or with the coroner. The body must be buried, cremated, or removed, and in any event within 72 hours after death.

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5M 9/60

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Howard</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>elkview</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u> <u>13X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Gen. Hosp</u>		d. STREET ADDRESS <u>Dorsey mill Rd</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Edward Anderson</u>		<b>4. DATE OF DEATH</b> <u>Dec 22 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-61</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Vernon Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Asphyxia</u> DUE TO (b) <u>supper Respiratory Infection</u> DUE TO (c) <u>—</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		22d. LOCATION (City, town, or country) (State) <u>Clarksville, Md</u>	
23. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

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VR A15 (4)  
15M 9/60

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14013

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 28</u> d. STREET ADDRESS <u>2001 Hanover St S1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Andrew</u> Last <u>Anderson</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17-1889</u> yrs.	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - office worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Andrew Anderson</u>			14. MOTHER'S MAIDEN NAME <u>Hanna Borgenson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>577-10-3205</u>		
17. INFORMANT <u>Mr. Robert A. Anderson</u> <u>Syn. 12,600 Barbara Road, Silver Spring, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension - Arteriosclerosis</u> (c) <u>Heart Disease</u> DUE TO cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955 to Dec 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 4, 1961</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>J. Marion Barkhead</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>J. Marion Barkhead</u>			22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/7/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CADDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGE'S, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harper E. Pumphrey, Inc.</u>			25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

23051



(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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14046  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montg.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wilbur</b> Last <b>Arnold</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 16-1880</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Washington Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virginia Martzell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records. Asbury Methodist Home</b>		Address <b>Gaithersburg</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, Generalized</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Prostate</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>13 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1960</b> to <b>Dec. 19</b> 1961, that (I) (we) last saw the deceased alive on <b>Dec 14</b> 1961, and that death occurred at <b>11:23</b> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>James W. Egan</b>		22b. DATE SIGNED <b>12-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James W. Egan</b>		22d. ADDRESS <b>7720 Wisconsin Ave. - Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Sandy Mount. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>			

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CONFIDENTIAL  
CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14047

14015

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8000 PINEY BRANCH ROAD</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 TAKOMA PARK</b> d. STREET ADDRESS <b>18000 PINEY BRANCH ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAISY E. BARNHART</b>		4. DATE OF DEATH <b>DEC. 25, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 13, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DAVID FRYE</b>		14. MOTHER'S MAIDEN NAME <b>IDA NICHOLSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>STANLEY R. BARNHART 8000 PINEY BRANCH RD.</b>	
17. INFORMANT <b>STANLEY R. BARNHART</b>		Address <b>TAKOMA PARK, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, Renal Failure</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Glomerulo Nephritis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 y 4</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>June 1961</b> to <b>25-Dec., 1961</b> , that (I) (we) last saw the deceased alive on <b>24 Dec. 1961</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. B. QUEEN M.D.</b>		22b. DATE SIGNED <b>25-Dec-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. B. QUEEN</b>		22d. ADDRESS <b>7112 Willow Ave. TAKOMA PARK, MD.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LIGONIER VALLEY CEM.</b>		23d. LOCATION (City, town or county) (State) <b>LIGONIER PENNA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Stoltz</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>	
ADDRESS <b>254 GARRON ST. N.W. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

1907

January

January 1st

2000 High Mountains

July 1st

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Housewife

David Page

On the

For the

January 1st 1907

1907

January

January 1st

2000 High Mountains

July 1st

W

Housewife

David Page

January 1st 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14048						14016					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY <i>Mercer</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princeton</i>				d. STREET ADDRESS <i>46 Chestnut Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>L.</i> Last <i>BARRON</i>						4. DATE OF DEATH Month <i>Dec</i> Day <i>10</i> Year <i>1961</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/19/88</i>		9. AGE (In years last birthday) <i>73 yrs.</i>		IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Librarian (ret.)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Princeton, N.J.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Nova Scotia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Canadian</i>	
13. FATHER'S NAME <i>Andrew Barron</i>						14. MOTHER'S MAIDEN NAME <i>Mary?</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Edw. P. Carr / Bethesda, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420</i> DUE TO <i>Infarction of myocardium</i> Conditions, if any, which gave rise to immediate cause (b) <i>Coronary atherosclerosis</i> (c) <i>Generalized arteriosclerosis</i> DUE TO <i>Generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Spring</i> , 19 <i>60</i> to <i>Dec 10</i> , 19 <i>61</i> , that (I) <del>was</del> last saw the deceased alive on <i>Dec 10</i> , 19 <i>61</i> , and that death occurred at <i>1:30</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>James W. Egan</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-10-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>James W. Egan</i>						22d. ADDRESS <i>7720 Wisconsin Avenue, Bethesda Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<i>Burial-Transit</i>		<i>12/11/61</i>		<i>St. Paul Cemetery</i>		<i>Princeton, New Jersey</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 13 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14049				CERTIFICATE OF DEATH				14017			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Scotland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmore Sanitarium &amp; Hospital</b>						d. STREET ADDRESS <b>184-J</b>					
3. NAME OF DECEASED (Type or print) <b>Harry Alexander Beal</b>						4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1872</b>		9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR: Months <b>18</b> Days <b>4</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>? ?</b>						14. MOTHER'S MAIDEN NAME <b>? ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>? ?</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Same as # 2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY ARTERY DISEASE</b> (c) <b>ARTERIO SCLEROSIS, GENL</b> cause last. <b>10+ YEARS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>5+ YEARS</b> <b>10+ YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>URINARY TRACT INFECTION WITH UREMIA</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 17 1961</b> to <b>12/10/61</b> , that (I) (we) last saw the deceased alive on <b>12/9 1961</b> , and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles J. Savarose, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/11/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVAROSE, JR.</b>						22d. ADDRESS <b>4890 BATTERY LAKE BETHESDA, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		23d. LOCATION (City, town or county) <b>Ridge,</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>						ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Savarose</b>	

VR A15 (4)  
15M 9/60

(M)

11043

11043

Montgomery

Karyland

St. Mary's

Western

Central Scotland

Monroe Sanitarium & Hospital

Harry

Alexander

Deed

December 10, 61

Male

White

X

Feb. 1872

60

Farming

Karyland

U.S.A.

Hospital Records same as 4 & 5 above

St. Michael's

12/12/61

Burial

Highgate

St. Mary's

St. Mary's Rectory, Leonardtown, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14050									
14018									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN hb <b>3 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery Gen. Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Lewisdale</b> d. STREET ADDRESS <b>RFD Clarksburg</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Bessie Lewis Beall</b>					4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1961</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1893</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewisdale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Filmore Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Olive M. Watkins</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Leslie G. Beall, Item 2</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Generalized Arteriosclerosis with Coronary Sclerosis</b> DUE TO (c) <b>Hypertensive Arteriosclerotic Cardio-vascular Disease with Congestive Heart Failure.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>8 years ?</b> <b>5 years?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus - Severe. Congestive Heart Failure Hypertensive Arteriosclerotic Cardio-vascular Disease</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT, WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b></b> p.m. <b></b> 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20e. (City or town)		20f. (County)		20g. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1935</b> to <b>December 30, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred at <b>193</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>M. McKendree Boyer</b>					22b. DATE SIGNED <b>12/31/61</b>		22c. PHYSICIAN'S NAME (Type) <b>M. D. 9830 Main Street, Damascus, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 2, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Methodist</b>		23d. LOCATION (City, town or county) <b>Browningsville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mohaworth</b>				24a. ADDRESS <b>Damascus, Md.</b>		24b. REC'D BY REGISTRAR <b>JAN 4 1962</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



(M)

1050

Confidential

Only

2 weeks

House - Lafayette

Confidential Non. Hospital

RD. Dismal

Beats Lewis Bell

November 30

July 21, 1893

Female White

Cam home

Lafayette, La.

Wilmington

Olivia M. Watkins

Home

Mr. Leslie O. Bell, Item 2

Dec. 30, 1901

*Handwritten signature*

Jan. 2, 1902 Bethesda Methodist

Dallas, La.

Brownsville, La.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14051

14019

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>4605 West Va. Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN M BECK</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/12/1901</b>		9. AGE (In years last birthday) <b>60</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painting Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>George W. Beck</b>		14. MOTHER'S MAIDEN NAME <b>Icey Lindsay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>325-14-2167</b>	
17. INFORMANT <b>Lillian S. Beck</b>		Address <b>Wife Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> DUE TO (b) <b>Thrombosis, Left anterior descending coronary artery</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>JUNE 22</b> , 19 <b>61</b> , to <b>DEC. 31</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec. 30</b> , 19 <b>61</b> , and that death occurred at <b>9:35A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Angle</b>		22b. DATE SIGNED <b>12/31/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Angle</b>		22d. ADDRESS <b>5009 DelRay Avenue, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	



11051

Myocardial infarct  
Thrombosis left anterior descending  
artery

3000 Dallas Avenue, Houston, TX

1/5/62

Robert A. Brumley and Barbara, M.D.

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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14052  
CERTIFICATE OF DEATH  
14020

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clarksburg c. LENGTH OF STAY IN b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD # 1		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clarksburg d. STREET ADDRESS RFD # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Della F. Bennett		4. DATE OF DEATH Month Day Year Dec. 12 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1882 9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME W.F.L. Clagett	
14. MOTHER'S MAIDEN NAME Heneriletter Watkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. ----		17. INFORMANT Dosey L. Bennett, Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease 443X DUE TO Auricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Gastro-enteritis (Viral?)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs. 14 yrs. 15 yrs. ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not an accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1941 to December 12, 1961 (we) last saw the deceased alive on December 12, 1961, and that death occurred at 2P.M. from the causes and on the date stated above.			
22a. SIGNATURE M. McKendree Boyer		22b. DATE SIGNED Dec. 13, 1961	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22d. ADDRESS 9830 Main Street, Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Clarksburg Meth.		23d. LOCATION (City, town or county) (State) Clarksburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molsworth		25a. REC'D BY REGISTRAR DATE DEC 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14053  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
14021

1. PLACE OF DEATH - a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>		c. LENGTH OF STAY IN 1b <b>4mo.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>Washington D.C.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>		d. STREET ADDRESS <b>4607 Conn. Ave. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elsie Havener Bennett</b>		First		Middle		Last		4. DATE OF DEATH <b>December 17, 1961</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Sept. 11, 1878</b>		9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk General Accounting office</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Wesley Francis Havener</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ann Cleary</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>Mrs. Elsie H. Bennett,</b>		17. INFORMANT <b>Address</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>321X</b> IMMEDIATE CAUSE (a) <b>Coronary artery accident</b> <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychiatric status</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b> <b>js</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>12/11, 1959 to 12/19, 1961</b>		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <b>12/11, 1959</b> to <b>12/19, 1961</b> that (I) (we) last saw the deceased alive on <b>12/12, 1961</b> , and that death occurred at <b>12/19, 1961</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>C. H. Wolohon</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>C. H. Wolohon</b>		22d. ADDRESS <b>800 Pershing Dr. Silver Spring, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) <b>Rock Creek Church Rd. Wash. DC</b>		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>									

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Medical Record

Clinical

James P. [Signature]



15085

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "for" are faintly visible.]*

1/10  
FOR STATE  
HEALTH DEPT.

(M)

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MEDICAL CERTIFICATION

VS. A1SME  
5M 9/60

<div> <div> <div>1/10</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>14056</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>14024</div> </div> </div> <div> <div> <div>1</div> <div>PLACE OF DEATH</div> </div> <div> <div>2</div> <div>USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> </div> </div>													
<div> <div>1. PLACE OF DEATH</div> <div> <div>a. COUNTY</div> <div>Montgomery</div> </div> <div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Elkridge</div> </div> <div> <div>c. LENGTH OF STAY IN 1b</div> <div>Do A</div> </div> </div>				<div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div> <div>a. STATE</div> <div>md</div> </div> <div> <div>b. COUNTY</div> <div>montg</div> </div> <div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>15. Silver Spring</div> </div> </div>									
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Montg Gen. Hosp</div> </div>				<div> <div>d. STREET ADDRESS</div> <div>Colesville-Beltville Rd</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>John Bixiones</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>12-18-1961</div> </div>									
<div> <div>5. SEX</div> <div>male</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>white</div> </div>		<div> <div>7. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>12-19-24</div> </div>		<div> <div>9. AGE (In years last birthday)</div> <div>36 yrs.</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> </div>			
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Dep Sheriff</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Montgomery Co.</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Pa</div> </div>					
<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>41-S-G</div> </div>				<div> <div>13. FATHER'S NAME</div> <div>Peter Bixiones</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Alice Christos</div> </div>					
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>Yes</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> <div>WW2 149-12-5240</div> </div>				<div> <div>17. INFORMANT</div> <div>Joe P. Bixione - 13201 Kapa Lane Silver Spring</div> </div>					
<div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Asphyxia</div> <div>929.8 DUE TO</div> <div>(b) Drowning</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO</div> <div>(c)</div> </div> </div>										<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>Sudden</div> </div>			
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div>													
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</div> <div><input checked="" type="checkbox"/></div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)</div> <div>Drowned while retrieving a duck which he shot</div> </div>									
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour e.m. p.m.</div> <div>12-18 1961</div> </div>				<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div> </div>		<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Pond</div> </div>		<div> <div>20f. (City or town)</div> <div>Silver Spring</div> </div>		<div> <div>(County)</div> <div>Montg</div> </div>		<div> <div>(State)</div> <div>md</div> </div>	
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>													
<div> <div>ACTUAL SIGNATURE</div> <div>Frank J. Broschart</div> </div>				<div> <div>CHIEF MEDICAL EXAMINER</div> <div><input type="checkbox"/></div> </div>				<div> <div>DATE SIGNED</div> <div>12-18-61</div> </div>					
<div> <div>EXAMINER'S NAME (Type)</div> <div>FRANK J. Broschart</div> </div>				<div> <div>ASSISTANT MEDICAL EXAMINER</div> <div><input type="checkbox"/></div> </div>				<div> <div>DEPUTY MEDICAL EXAMINER</div> <div><input checked="" type="checkbox"/></div> </div>					
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>				<div> <div>22b. DATE THEREOF</div> <div>12/21/61</div> </div>		<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Arlington National Cemetery</div> </div>		<div> <div>22d. LOCATION (City, town, or country)</div> <div>Arlington Virginia</div> </div>					
<div> <div>23. FUNERAL DIRECTOR</div> <div>Raymond A. Ziska</div> </div>				<div> <div>ADDRESS</div> <div>8434 Georgia Avenue</div> </div>				<div> <div>24a. REC'D BY REGISTRAR</div> <div>DEC 22 '61</div> </div>		<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>William S. Kline</div> </div>			

VS. A1SME  
5M 9/60





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14057

## CERTIFICATE OF DEATH

14025

Item 23b, Film G303-12/19/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Louisiana</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bossier City</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>2273-A N. Plantation Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> <u>Leslie</u> <u>Blackwell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>November 11, 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) yrs. <u>1</u> Months <u>5</u> Days <u>5</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerry D. Blackwell</u>		14. MOTHER'S MAIDEN NAME <u>Sybill Bizzell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -	
17. INFORMANT <u>FATHER: Jerry D. Blackwell, sam as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>(Transposition = A.S.D. &amp; U.S.D.)</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>31 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 26, 1961</u> , to <u>Dec. 12, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 12, 1961</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M.C. O'Bannon</u>		22b. DATE SIGNED <u>December 12, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. O'BANNON LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Smyrna Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Smyrna, Ga.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>		25c. ADDRESS <u>1331 E. Montgomery Ave Rockville, Md</u>	

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14035

CERTIFICATE OF DEATH

14035



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14058

Items 4, 18 & 22 Film G302 12/8/61 iwk

14026

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence Before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Loudoun</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg</u> d. STREET ADDRESS <u>P.O. Box 628</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ruby</u> Middle <u>Lee</u> Last <u>Bodmer</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>5</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>September 24, 1912</u>
<b>9. AGE</b> (In years last birthday) <u>49</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>19</u> Hours <u>15</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Telephone Company</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Robert G. Cooper</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ollie Atwell</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>223-09-1520</u>	
<b>17. INFORMANT</b> <u>The Medical Record</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure, probably due to acute tubular necrosis</u> DUE TO <u>Massive hemorrhage</u> (b) <u>retroperitoneal, peritoneal, peri-renal.</u> DUE TO <u>triangle</u> (c) <u>Abcess, right femoral triangle, thrombosis R. iliac vein</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 days</u> <u>9 days</u> <u>14 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 8, 1961</u> to <u>Dec. 5, 1961</u> that <u>we</u> (we) last saw the deceased alive on <u>Dec. 5, 1961</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Josef H. Pilch</u>		<b>22b. DATE SIGNED</b> <u>12/5/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Josef H. Pilch, M.D.</u>		<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec. 8, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Leesburg</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Leesburg</u> <u>VA</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. L. Muse</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 8 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u> d. STREET ADDRESS <u>1 519 Crabbs Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mark Preston Bonner</u>				4. DATE OF DEATH Month Day Year <u>Dec. 23 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>12/24/61</u>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Bonner</u>				14. MOTHER'S MAIDEN NAME <u>Loyce M. Mc Kinney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>Mother's Chart.</u>			
17. INFORMANT <u>Mother's Chart.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <u>Atelectasis</u> <u>Prematurity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>-</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> , 19 <u>61</u> , to <u>12-23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-23</u> , 19 <u>61</u> , and that death occurred at <u>12-23</u> , 19 <u>61</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis J. Troendle</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>				22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 E. Montgomery Ave. Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hazzard</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14060

14028

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8403 Old Georgetown Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Bowling</b>		4. DATE OF DEATH <b>December 12, 1961</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/20/78</b>	
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mechanic Capitol Transit Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fredericksburg, Va. U.S.A.</b>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Florence Bowling</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>5 year</b> <b>10 year</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1940</b> to <b>Dec 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 10, 1961</b> and that death occurred <b>4:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert E. Maher M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert E. Maher M.D.</b>		22d. ADDRESS <b>1835 Eye St. N.W. Wash 6, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		25. REC'D BY REGISTRAR <b>DEC 15 '61</b>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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The S. A. Miner Company

Washington D. C.

June 21, 1911

Dear Sir:

Enclosed herewith

is a copy of

the report of the

committee on the

subject of the

proposed changes in

the constitution of

the S. A. Miner

Company, which you

will find of interest

and I hope will

be of service to you

in your work.

Very truly yours,

W. A. Miner

Secretary

S. A. Miner

Enclosure

Very truly yours,

W. A. Miner

Secretary

S. A. Miner

Enclosure

Very truly yours,

W. A. Miner

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S. A. Miner

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Very truly yours,

W. A. Miner

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S. A. Miner

Enclosure

Very truly yours,

W. A. Miner

Secretary

S. A. Miner

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14061

## CERTIFICATE OF DEATH

14029

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>1 Month</u>		d. STREET ADDRESS <u>8611 Mayfair Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anita</u> Middle <u>South</u> Last <u>Bracy</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Uta h</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Marcus Pliny Sawtelle</u>		14. MOTHER'S MAIDEN NAME <u>Caesaria Armigo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>571-38-7152A</u>	
17. INFORMANT <u>Mrs. Emma Watterson (daughter)</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>arteriosclerotic Cardiovascular Disease</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>422-1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 1, 1961</u> to <u>Dec 5, 1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Dec 5, 1961</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>George B. Patrick Jr</u> M.D.		22b. DATE SIGNED <u>12-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick, Jr MD</u>		22d. ADDRESS <u>9221 Colesville Rd, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/8/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN MAUSOLEUM</u>		23d. LOCATION (City, town, or county) <u>PRINCE GEORGE'S MARYLAND</u> (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>434 GEORGIA AVENUE</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
25c. DATE <u>DEC 7 '61</u>		25d. <u>  </u>	

(M)

WARRNER & PATTERSON, INC., SILVER SPRING, MARYLAND  
1323 GEORGIA AVENUE  
SILVER SPRING, MARYLAND

George Washington, MS. Silver Spring, Md.  
1323 Georgia Ave.  
Silver Spring, Md.

Box 3  
April 1, 1962

Continental Card Corporation  
Central Headquarters  
1000 ...

Thomas King ...

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HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14030

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Rocky River</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 hours</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rocky River</b>		d. STREET ADDRESS <b>21641 Lake Rd.,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Wirsing</b> Last <b>Bradshaw</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1886</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Tullner</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Engel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Wm. W. Tullner, 5909 Greenlawn Dr., Beth., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal hemorrhage</b> <b>451X</b> DUE TO (b) <b>Rupture of abdominal aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>History of aneurysm the past 5 years.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-7-61</b>	
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 12-10-61</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b>	22d. LOCATION (City, town, or country) (State) <b>Cuyahoga County, Ohio</b>				
23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# CERTIFICATE OF DEATH

Reg. Dist. No. 1031

## MEDICAL CERTIFICATION

1962

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE AND TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH  
JUNE 22 1922  
JUNE 23 1922

U. S. GOVERNMENT

LABORATORY

DEATH CERTIFICATE

MR. HANCOCK

100 HANCOCK ST. N. E.  
DETROIT, MICH.

DATE

NO. OF DEATH

U. S. GOVERNMENT

DEATH CERTIFICATE

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FOR STATE  
HEALTH DEPT.  
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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14032											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Va.</b> b. COUNTY <b>Arlington</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>3730- N.P ershing Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Herbert A. Breakey</b>				4. DATE OF DEATH <b>Dec. 13 19 61</b>							
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Economist (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>				11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>John Abner Breakey</b>				14. MOTHER'S MAIDEN NAME <b>M ary Lantz</b>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes World War I</b>				16. SOCIAL SECURITY NO. <b>_____</b>				17. INFORMANT <b>Daisy M. Breakey/ same as above.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Rupture of Thoracic Aorta</b> DUE TO (c) <b>Arterio sclerotic aneurysm</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				M.D. <b>FRANK J. Broschert</b>				DATE SIGNED <b>12-14-61</b>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>12/18/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Ft. Myer, Va.</b>		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>				ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>DEC 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



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FOR STATE  
HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14033

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>32 hrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47 X-3</b>		d. STREET ADDRESS <b>1226 D Street N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AUDREY BROOKS</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/22</b>		9. AGE (In years last birthday) <b>39 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b> Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kraft Murphy Cons. Co</b>		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>		13. FATHER'S NAME <b>AUDREY BROOKS</b>		14. MOTHER'S MAIDEN NAME <b>FLOSSIE LONDON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>238-20-7569</b>			
17. INFORMANT <b>Hospital record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central hemorrhage &amp; laceration</b> DUE TO (b) <b>Fracture of skull</b> DUE TO (c) <b>fall</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>34 hrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Working on construction job and fell 40 feet from scaffold to concrete floor.</b>		20c. TIME OF INJURY Month, Day, Year <b>12/19/61</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10201 Georgia Ave. Silver Spring, Md.</b>	
20f. (City or town) <b>Silver Spring, Md.</b>		20g. (County) <b>Mont.</b>		20h. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/21/61</b>			
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/24/61</b>		22b. DATE THEREOF <b>12/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>N.C.</b>		22d. LOCATION (City, town, or country) (State) <b>King Mountain N.C.</b>		23. FUNERAL DIRECTOR <b>R.N. HORTON Co. 1324 U.S.</b>		24a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14066

14034

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in lb <b>193 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>R.D.#3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Regina Gabrielle Brown</b>			4. DATE OF DEATH Month Day Year <b>December 23, 19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1943</b>	9. AGE (In years last birthday) <b>18 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Carl Brown</b>			14. MOTHER'S MAIDEN NAME <b>Regina M. Goss</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRam negative septicemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastro-intestinal ulceration</b> DUE TO (c) <b>Acute myelogenous leukemia</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Serum hepatitis, drug hepatitis, gastro-intestinal hemorrhage, bacterial pneumonia</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>pneumonia</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 13, 19 61</b> to <b>December 23, 19 61</b> that (I) (we) last saw the deceased alive on <b>December 23, 19 61</b> and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Thorne S. Winter, III, M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>12-23-61</b>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Thorne S. Winter, III, M.D.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/26/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chaster Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>			25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14067

CERTIFICATE OF DEATH

14035

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 Monday</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> <u>1657-2</u> d. STREET ADDRESS <u>1415 RUATAN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rose</u> <u>MARY</u> <u>BUNT</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1961</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR. 7-1907</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>			
13. FATHER'S NAME <u>ERNEST Bodeker</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE Piper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic renal disease</u> (a), stating the underlying cause last. } DUE TO <u>Diabetes mellitus</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>1 year</u> <u>unknown</u> <u>15 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>July 17, 1961</u> to <u>Dec. 8, 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Dec. 7, 1961</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>EINO MAGI</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-8-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>918 University Blvd. E. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince George's County, Md.</u>			
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Walters</u> ADDRESS <u>254 Carroll St NW DC</u>					
25a. RECEIVED BY REGISTRAR <u>DEC 13 1961</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14068

## CERTIFICATE OF DEATH

14036

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> <span style="float: right;">c. LENGTH OF STAY IN 1b <b>1 day</b></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Howard</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b> <span style="float: right;"><b>13X-2</b></span> d. STREET ADDRESS <b>Hallshop Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thomas Frank Butler</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>30</b> Year <b>1961</b>															
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1880</b> <b>1880</b> <b>81</b>		<b>9. AGE</b> (In years last birthday) Months <b>12</b> Days <b>30</b> Hours <b>1961</b> Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>unemp.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>									
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>218-32-3334</b>				<b>17. INFORMANT</b> <b>Hospital Records</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b> DUE TO (b) <b>Aretriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Nephrosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 months</b>  <b>20 years</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Sept. 18, 1961</b> to <b>Dec. 30, 1961</b> , that (I) <b>xxx</b> last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.										<b>22a. SIGNATURE</b> <b>Dr. C.S. Whitaker</b> <span style="float: right;">M.D.</span> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. C.S. Whitaker</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Clarksville, Maryland</b>		<b>22b. DATE SIGNED</b> <b>12-31-61</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>1-2-1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bushy Park</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Glenwood, Md</b>									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>F.C. Higinbotham, Ellicott City, Md</b>						<b>25a. REC'D BY REGISTRAR</b> <b>JAN 3 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



Montgomery

Olney

1 day

Montgomery General Hospital

Thomas Frank Butler

colored

male

Wm. G.

Maryland

1 day 11 day

Hospital Records

Chronic myocardial failure

Arteriosclerotic heart disease

Acute cardiac

Dec. 30, 1911

Dr. C. S. Whitaker

Clarkeville, Maryland

11-21-11

1-1-12

Montgomery General Hospital



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

14069

14037

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens San.</b>				d. STREET ADDRESS <b>4405 East-West Highway</b>			
3. NAME OF DECEASED (Type or print) <b>Henrietta Kibble Carrick</b>				4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1880</b>		9. AGE (In years last birthday) <b>81</b> yrs.	10. UNDER 1 YEAR Months <b>1</b> Days <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexandria Kibble</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ( Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-30-6117B</b>		17. INFORMANT <b>Elmer Carrick-Husband-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>331X</b> DUE TO <b>Cerebral arterio sclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inanition.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>56 Dec 6, 1961</b> to <b>11-30-1961</b> that (I) <b>me</b> lost saw the deceased alive on <b>11-30-1961</b> and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George H. Gray, Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Geo. H. GRAY, JR., MD.</b>		22d. ADDRESS <b>4740 Chevy Chase Dr. Chevy Chase, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 14038

14070

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>618 - Monroe St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen B.</u> Middle <u>Catron</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Catron</u>		14. MOTHER'S MAIDEN NAME <u>L. Anna Dennison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Ruth Johnson</u> Address <u>184 Allison Rd., Rockville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u></u> 19 <u></u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>12/6/61</u> to <u>12/9/61</u> , that I last saw the deceased alive on <u>12/9/61</u> , 19 <u></u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>12620 Georgia Ave., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		DATE SIGNED <u>12/9/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1531 E. Montg. Ave. Rockville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS

CERTIFICATE OF DEATH

1900

10

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

# 1 FOR STATE HEALTH DEPT

any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg md.</u> d. STREET ADDRESS <u>General Delivery</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Alice Irene Chase</u> First Middle Last 4. DATE OF DEATH <u>Dec 17 1961</u> Month Day Year						5. SEX <u>F</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 22 1923</u> 9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Clarksburg md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 13. FATHER'S NAME <u>Marshall Day</u> 14. MOTHER'S MAIDEN NAME <u>Alice Irene Pearson Chase</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Husband James Chase Same</u> Address						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> (c) <u>Tracheo bronchitis, severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>12-18-61</u>											
22a. BURIAL, CREMATION, REBURY (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
<u>Rockville</u>				<u>12/21/61</u>		<u>Rocky Hill.,</u>		<u>Clarksburg, Md.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

99

2

6:05 pm

2

2

1901

1902

General Delivery

1903

Alice Francis  
Husband Charles Francis

Day

March 11

1904

1905

1906



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)  
(C)  
75  
(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14072 CERTIFICATE OF DEATH 14040											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel,</b> d. STREET ADDRESS <b>Patuxent Research Refuge,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Clark</b>		4. DATE OF DEATH <b>December 10, 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 10, 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>		9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>Gordon Marston Clark</b>				14. MOTHER'S MAIDEN NAME <b>Esther Anne Janney</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>father</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - 26 wks. gestation</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>90 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Valgene M. Milstead,</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/10/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Valgene M. Milstead, M. D.</b>						22d. ADDRESS <b>1110 Spring St., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Washington San. &amp; Hospital</b>				ADDRESS <b>DEC 14 '61</b>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Orin S. Hines</b>			

2075332XV1

11072



Montgomery

Takota Park

Washington Sanitation and Hospital

Clark

Washington ID, 1981

Miller

Bole

Mayland

no

no

Army

Army

Clark

Harvey

Gordon

Takota

no

no

no

11072-21-11-71

Valerie H. Winston, R.N.

11-11-71

Robert A. Hays, M.D. Washington San. & Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14073

## CERTIFICATE OF DEATH

14041

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>35 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>11516 Georgia Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>De Sales</u> Last <u>Clark</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>18</u> Year <u>19 61</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Service Man</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wash. Gas Co.</u>		<b>8. DATE OF BIRTH</b> <u>July 10, 1894</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Frank Albert Clark</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Connolly</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-07-7800A</u>			
<b>17. INFORMANT</b> <u>The Medical Record</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the lung with metastasis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 13, 19 61</u> to <u>December 18, 19 61</u> that <u>  </u> (we) last saw the deceased alive on <u>December 18, 19 61</u> and that death occurred at <u>  </u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>John C. Marsh</u>		<b>22b. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		<b>22c. DATE SIGNED</b> <u>12/19/61</u>			
<b>22d. PHYSICIAN'S NAME</b> (Type) <u>John C. Marsh, M.D.</u>		<b>22e. REC'D BY REGISTRAR</b> <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-21-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Washington</u>		<b>23e. (State)</b> <u>D. C.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis J. Collins</u>		<b>24b. ADDRESS</b> <u>Wash. D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 1961</u>			
<b>24c. NAME</b> <u>FRANCIS J. COLLINS</u>		<b>24d. ADDRESS</b> <u>3821 14th. St. N. W.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Marsh</u>			

FRANCIS J. COLLINS 3821 44th St. N.W.

Wash. D.C.

Mt Oliver Cemetery

Washington

D. C.

Burial

12-21-61

John C. Smith, W.D.

December 12

x

November 12

x

12/12/61

x

The Office of the  
Inspector of the  
Department of the Army  
Washington, D.C.

Instructions

277-07-1800

for the

for the

Wash. Gas Co.

Washington, D.C.

White

x

July 10, 1961

by

Contract

to

from

1115 Georgia Avenue

The National Center, Building 12

22 days

When

Callum P. King



11/10/1911

General Nelson



## MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60

19013

19013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div style="display: flex; justify-content: space-between;"> <span>13</span> <span>14076</span> <span>CERTIFICATE OF DEATH</span> <span>14044</span> </div> <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Residence</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>334 1/2 22-Independence St -</u> d. STREET ADDRESS <u>Rockville - Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>RUTH</u> Middle <u>C</u> Last <u>COOPER</u>						<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>31</u> Year <u>1961</u>											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 18, 1891</u>		<b>9. AGE</b> (In years last birthday) <u>70</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Tex - Mex - Va -</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>									
<b>13. FATHER'S NAME</b> <u>Rosenberger</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>W</u>				<b>16. SOCIAL SECURITY NO.</b> <u>220-09-3336</u>		<b>17. INFORMANT</b> <u>Forraine Myer</u>				<b>Address</b> <u>334 1/2 22-Independence St - Rockville - Md</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u> <u>years</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>						
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March, 1958</u> <b>to</b> <u>Dec. 31, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 31, 1961</u> , <b>and that death occurred at</b> <u>11:30 P.M.</u> <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Abraham W. Danish</u>						<b>22b. ADDRESS</b> <u>1106 Spring St. Silver Spring</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ABRAHAM W. DANISH MD</u>		<b>22d. DATE SIGNED</b> <u>1-1-62</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Jan 4, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>The Union Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Rockville Montg. Md.</u>		<b>(State)</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Patterson</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DATE JAN 3 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Patterson</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14077

14045

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>27 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park 17</b> d. STREET ADDRESS <b>516 Domer Ave, Apt. # 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Darwin (n)</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 Jan. 1910</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew CORSO</b>		14. MOTHER'S MAIDEN NAME <b>Laura MATTEA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	
17. INFORMANT <b>(W) Edith M. CORSO</b>		Address <b>Same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of esophagus</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>---</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>11-10-61</b> , 19 <b>61</b> , to <b>12-8</b> , 19 <b>61</b> , that (b) (we) last saw the deceased alive on <b>12-8</b> , 19 <b>61</b> , and that death occurred at <b>6: A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J.W. Brackett Jr.</b> M.D.		22b. DATE SIGNED <b>12-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.W. BRACKETT JR. LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Douglas Johnson</b> ADDRESS <b>RINALDI FUNERAL HOME 7400 GEORGIA AVE, SS, MD.</b>		25a. REC'D BY REGISTRAR <b>DEC 11 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11121 Newport Mill Road</b>		d. STREET ADDRESS <b>11121 Newport Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>Carol Louis Cox</b>		4. DATE OF DEATH <b>December 16 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/1887</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR <b>9</b> Months <b>15</b> Days	11. IF UNDER 24 HRS. <b>1</b> Hour <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book seller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Books</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles P. Cox</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>102-28-4973</b>	
17. INFORMANT <b>Robert R. Cox-Son-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Recurrent Pleural Effusion</b> DUE TO (c) <b>Chronic Heart Failure - Post Coronary</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>1 year</b> <b>2 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>March, 1961</b> , to <b>16 Dec, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>16 Dec, 1961</b> , and that death occurred <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ann M. Dimitroff</b> M.D.		22b. DATE SIGNED <b>12/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ann M. Dimitroff</b>		22d. ADDRESS <b>11300 Woodson Avenue, Kens, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>12/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wood Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>New York, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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Montgomery

Maryland

Washington

Washington

1121 Newmont Mill Road

1121 Newmont Mill Road

Gayel

Box

Washington 10

Name

Wife

2/21/1987

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Book seller

Books

New York

1121

Charles E. Fox

Washington

100-25-4173 Robert R. Fox-Son-are 84

11501 Woodson Ave  
Baltimore, MD 21206

11501 Woodson Avenue, Baltimore, MD

Bureau Transmittal 12/18/81

100 East Lexington

New York, NY 10017

Robert A. Bushmeyer, Bethesda, Maryland

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14079											
14047											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>					c. LENGTH OF STAY IN lb <i>3 days</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>					d. STREET ADDRESS <i>9214 Mintwood St.</i>						
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>Alberta</i> Last <i>Cox</i>					4. DATE OF DEATH Month <i>12</i> - Day <i>15</i> Year <i>1961</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-1-76</i>		9. AGE (In years last birthday) <i>85</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. G.</i>		
13. FATHER'S NAME <i>John W. Taylor</i>					14. MOTHER'S MAIDEN NAME <i>Tabertha Suttle</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address <i>Washington Sanitarium &amp; Hospital</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCT? DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS ; ABDOMINAL AORTIC ANEURYSM ; CARCINOMA OF BREAST.</i>										INTERVAL BETWEEN ONSET AND DEATH <i>MANY YRS.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28</i> , 19 <i>61</i> , to <i>Dec. 15</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>12-14</i> , 19 <i>61</i> , and that death occurred at <i>12-15-61</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Dwight R. Smith</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-15-61</i>				
22c. PHYSICIAN'S NAME (Type) <i>DWIGHT R. SMITH, M.D.</i>					22d. ADDRESS <i>1015 SPRING ST. SILVER SPRING, MD</i>						
23a. (BURIAL) CREMATION. REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>12-18-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Taylor Mem. Cem</i>		23d. LOCATION (City, town or county) (State) <i>Colonial Beach Va</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Deaf Funeral Home</i> ADDRESS <i>4812 He Ave NW Wash D.C.</i>					25a. REC'D BY REGISTRAR <i>DEC 21 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. France</i>				

11079

CERTIFICATE OF DEATH

11079

(M)

Washington Sanatorium Hospital 9214  
Takoma Park 3 days

Silver Spring

Nelle Albarran Cox

12-12-01

Frank White

2-1-76

82

Homer A. Taylor

1-1-76

1-1-76

John H. Taylor

1-1-76

1-1-76

Washington Sanatorium Hospital

Washington Sanatorium Hospital

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 7 & 14 Film G303 12/20/61 iwk

14048

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>55 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1805 Seeks Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Esther Crum</u>		4. DATE OF DEATH <u>Dec 10 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-97</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>John Albright</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pl's Chart.</u>		17. INFORMANT Address <u>unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-11-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Frederick, Maryland</u>		
23. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>

(M)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14049

14081

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 1/2 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u> d. STREET ADDRESS <u>8610 Garland Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Louis Aaron Davidoff</u>			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 31-88</u>		
9. AGE (In years last birthday) <u>73</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired shoe mfg.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe business</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ISRAEL DAVIDOFF</u>			14. MOTHER'S MAIDEN NAME <u>Liebe Lankus</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>028-039314</u>		
17. INFORMANT <u>Hospital Records</u>			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery disease</u> (a), stating the underlying cause last. } DUE TO (c) <u>Coronary arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension and peripheral arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>Dec 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 25</u> , 19 <u>61</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.						22b. DATE SIGNED	
22a. SIGNATURE <u>Saul Holtzman</u> M.D.						22c. PHYSICIAN'S NAME (Type) <u>Saul Holtzman</u>	
22d. ADDRESS <u>1800 Eye St. NW Wash DC</u>						22e. REC'D BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>12/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASHINGTON CEM</u>						23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deady Funeral Home</u> ADDRESS <u>4217-9th St</u>						25a. DATE <u>DEC 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>2 Kraus</u>						25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14082

14050

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>7019 Georgia Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Molly Ellen Davis</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1871</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Webb</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7019 Ga Ave NW</u>	
17. INFORMANT <u>Mrs Louise Kaldenbach</u>		Address <u>7019 Ga Ave NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm of R. lung &amp; M. lobe &amp; cystic duct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Recurrent Hypertension</u> (b) <u>She ca</u> (c) <u>may be</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/26/1961</u> to <u>12-26-1961</u> , that (I) (we) last saw the deceased alive on <u>12/26/1961</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H. Wolstein</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolstein</u>		22d. ADDRESS <u>7600 Carroll Ave Shome Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-29-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City, town or county) (State) <u>Switzland Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>	
ADDRESS <u>4812 Ga Ave NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 Film 305</div> <div>1-12-62</div> <div>305</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>14083</div> <div>14051</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Restmor</u>						d. STREET ADDRESS <u>8820 River Rd.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>James</u> <u>EDWARD</u> <u>DAY</u>						4. DATE OF DEATH Month Day Year <u>12</u> <u>3</u> <u>1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Samuel Day</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Kickett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-10-2703</u>				17. INFORMANT <u>Elsie Day-Wife-same 2d</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>053.4</u> DUE TO <u>Undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undetermined</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Med. status</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> , 19 <u>61</u> to <u>12/13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Alvin I. Kay</u> M.D.						22b. DATE SIGNED <u>12/13/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Alvin I. Kay MD</u>						22d. ADDRESS <u>1835 Eye St NW - Wash DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

(M)

(1)

Robert A. Humphrey, Bethesda, Maryland

12/5/51

State of Hawaii

12/5/51

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

570-10-2705 State Dev. - same 2d

*[Faint, illegible handwritten text]*

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12/5/51



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14084

Items 8 & 9 Film G303 12/20/61 iwk

14052

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in lb <u>One week</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				e. STREET ADDRESS <u>23 Silver Spring</u> <u>9301 Ocala St.</u>			
3. NAME OF DECEASED (Type or print) <u>Johanna</u> <span style="float: right;">(NMM) DeCarlo</span>				4. DATE OF DEATH Dec 8 1961			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21 1886</u> <u>December 18, 1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Jamele</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jackarosa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Nicholas C. DeCarlo</u> <u>19408 Pine Oak Drive, Silver Spring, MD.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute anterior</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 15, 1961</u> to <u>Dec. 8, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec. 8, 1961</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond Bradshaw</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				22d. ADDRESS <u>345 University Blvd W. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MONTGOMERY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Bisher</u> ADDRESS <u>8434 GEORGIA AVENUE</u> <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14085					14053				
1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			c. LENGTH OF STAY IN 1b <u>77 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home 18 Maryland Ave</u>					d. STREET ADDRESS <u>18 Maryland Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert Laurence Diamond</u>					4. DATE OF DEATH Month <u>Dec</u> Day <u>5th</u> Year <u>19 61</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15-1884</u>		9. AGE (In years last birthday) <u>77 yrs.</u> 3 Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John B. Diamond</u>					14. MOTHER'S MAIDEN NAME <u>Grace Ranney</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John B. Diamond 3rd. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Acute Left Ventricular Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
19									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1961</u> to <u>Dec. 5, 1961</u> , that (I) <u>(two)</u> saw the deceased alive on <u>12-5-1961</u> , and that death occurred at <u>12-6-61</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Jack Schumacher</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Rose</u>		23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Rural</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14086

14054

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital Bethesda, Md.		d. STREET ADDRESS 1107 Alabama Ave., S.E.	
3. NAME OF DECEASED (Type or print) First Lida Middle May Last DICE		4. DATE OF DEATH Month December Day 5th Year 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 February 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SHERWOOD, Joseph		14. MOTHER'S MAIDEN NAME FAIRALL, Sarah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT James D. DICE		Address 1107 Alabama Ave, S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of breast.</i> 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 24 October 1961 to 5 December 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5 December 1961, and that death occurred at 0015AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin J. Gilson</i>		22b. DATE SIGNED December 5, 1961	
22c. PHYSICIAN'S NAME (Type) BENJAMIN J. GILSON LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-8-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Order S. House</i>	
ADDRESS Simmons Funeral Home Good Hope Rd., S.E.		DATE DEC 7 '61	

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ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 01-11-01 BY 1043



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14087

## CERTIFICATE OF DEATH

Items 2 & 14 ~~XXXX/0302/~~ from birth cert 14055

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>34</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		d. STREET ADDRESS <b>11935 Andrews Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Boy</b>		4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1961</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-30-61</b>		9. AGE (In years last birthday) <b>12</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>60</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Nicholas Di Pietro</b>		14. MOTHER'S MAIDEN NAME <b>Emma A. Dinnis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACranial hemorrhage</b> <b>760.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Laceration of Tentorium Cerebelli</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 30</b> , 19 <b>61</b> , to <b>Dec 1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 1</b> , 19 <b>61</b> , and that death occurred at <b>DE 1</b> , 19 <b>61</b> , M, from the causes and on the date stated above.		22a. SIGNATURE <b>Jaw-Pearlman</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. NAME (Type) <b>AMELIA C. CARTER, Admin. - SUBURBAN HOSP. BETHESDA, MD</b>		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>12-2-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>SUBURBAN HOSPITAL</b>		23d. LOCATION (City, town or county) (State) <b>BETHESDA, MARYLAND</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>AMELIA C. CARTER, Admin. - SUBURBAN HOSP. BETHESDA, MD</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Univ. S. Thane</b>		25c. DATE		25d. SIGNATURE		25e. DATE			

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

14088  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14056

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>rear of 14615 Good Hope Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William E Dorsey</b>				4. DATE OF DEATH Month Day Year <b>12 8 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-6-1912</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Garfield Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pulmonary Intercolosis, et.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumorectomy left lung in distant part</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/8/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE OF DEATH <b>12/14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National.</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR <b>Robert L. Suowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert L. Suowden</b>			

MEDICAL CERTIFICATION



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 14089 CERTIFICATE OF DEATH 14057

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Md.</b>				c. LENGTH OF STAY IN 1b <b>9 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Catherine</b> First <b>Nelms</b> Middle <b>Downing</b> Last				4. DATE OF DEATH <b>Dec.</b> Month <b>11</b> Day <b>19</b> Year <b>61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1870</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>HEATHSVILLE, VA.</b>	
13. FATHER'S NAME <b>Gustavus Betts</b>				14. MOTHER'S MAIDEN NAME <b>Mary Basye</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. OSCAR B. DOWNING</b> Address <b>8407 Hartford Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral insufficiency</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>W. failure</b> DUE TO (c) <b>bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>sensitivity + cachexia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>6 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13, 1960</b> to <b>12/11/61</b> , that (I) (we) last saw the deceased alive on <b>12/11/61</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>MARVIN WADLER</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>12/11/61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>MARVIN WADLER</b>				22d. ADDRESS <b>8218 Wisconsin Av. Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b> ADDRESS <b>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>DEC 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	





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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14058

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt #1 Gaithersburg, Md</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mongomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Routel# Gaithersburg, Md</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Frances</b> Last <b>Duvall</b>		4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1934</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Moore</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Right Ovary.</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 19 61</b> to <b>Dec 5, 19 61</b> , that (I) (we) last saw the deceased alive on <b>Dec 3, 19 61</b> , and that death occurred at <b>3:10</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Luciano I. Led</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Led</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove.,</b>		23d. LOCATION (City, town or county) (State) <b>Laytonsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										14060	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN 1b <b>1/31/61</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WHEATON NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNA.</b> b. COUNTY <b>PLAINS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75X-3</b> d. STREET ADDRESS <b>27 PERKINS ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ROBERT JOSEPH ELWARD</b>						4. DATE OF DEATH <b>December 18 19 61</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1898 3/5/96</b>		9. AGE (In years last birthday) <b>62 65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>PLAINS, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>THOMAS J. ELWARD</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH LAMB</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Thomas Elward-Brother-Bethesda, Md.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HISTORY OF HYPERTENSION</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>FOUND DEAD IN BED</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Brosch</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12-18-61</b>					
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>						24a. REC'D BY REGISTRAR <b>DEC 21 '61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>12/19/61</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>						22d. LOCATION (City, town, or country) (State) <b>Hanover Township, Pa.</b>					
24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>						DATE					

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

Robert A. Remondy, Bethesda, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14093

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G505 12/21/61 1wk

14061

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON</i>	
3. NAME OF DECEASED (Type or print) <i>Rufus</i> First <i>P.</i> Middle <i>Embrey</i> Last		4. DATE OF DEATH <i>Dec</i> Month <i>7</i> Day <i>1961</i> Year	
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-29-84</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Embrey, R. J.</i>		14. MOTHER'S MAIDEN NAME <i>Savin, Katie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>LEE ANNA EMBREY - 1343 KALMIA RD NW</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO <i>4 4 7 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 WEEKS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>march 1959</i> to <i>DECEMBER 7 1961</i> , that (I) (we) last saw the deceased alive on <i>DECEMBER 6 1961</i> , and that death occurred at <i>12:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert L. Krichmar</i>		22b. DATE <i>DECEMBER 7 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR MD</i>		22d. ADDRESS <i>7733 AKASKA AVENUE N.W. WASHINGTON 12 D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-9-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>BLADENSBURG, MARYLAND</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home, Inc</i>		25a. REC'D BY REGISTRAR <i>DEC 13 '61</i>	
ADDRESS <i>4812 GEORGIA AVE WASHINGTON, D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14094

## CERTIFICATE OF DEATH

14062

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN b <b>10</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>409 West Montgomery Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>409 West Montgomery Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Edward England</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1869</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. England</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hendry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Churchill E. Ward-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Senility. (Age 92)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2 years</b> <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Dec 10 - 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 10 - 1961</b> , and that death occurred <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. A. Linthicum</b>		22b. DATE SIGNED <b>12/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. A. Linthicum</b>		22d. ADDRESS <b>110 S. Washington St. Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



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Montgomery

Montgomery

Rockville

Rockville

400 East Montgomery Avenue

400 East Montgomery Ave.

Charles

England

Male

White

May 10, 1969

May 10, 1969

Robert A. Humphrey, Director

Montgomery

USA

John W. England

May 10, 1969

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Rockville, Maryland

Rockville, Maryland

Robert A. Humphrey, Director

Robert A. Humphrey, Director

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14063											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Urbey</u>				c. LENGTH OF STAY IN 1b <u>D.V.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> <u>14</u>				d. STREET ADDRESS <u>Brookman Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mntg. Gen. Hosp</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Marie Rosietta Evans</u>						4. DATE OF DEATH <u>Dec 11 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-61</u>		9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>James Evans</u>						14. MOTHER'S MAIDEN NAME <u>Clara Jackson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give year or dates of service) <u></u>						16. SOCIAL SECURITY NO. <u></u>					
17. INFORMANT <u>Clara Evans (mother)</u>						Address <u>Stu 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-11-61</u>					
Address (Street, city, town, or county) <u></u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Round Oak.</u>				22d. LOCATION (City, town, or country) (State) <u>Spencerville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>						24a. REC'D BY REGISTRAR <u>DEC 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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14064

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1656-2 8112 New Hampshire Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henriche EASTON</u> First Middle Last 4. DATE OF DEATH <u>12-18-1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-2-85</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James L. Easton</u> 14. MOTHER'S MAIDEN NAME <u>Mary E Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Brother. (Mr. Wm H. Easton)</u> Address <u>Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Thrombosis superior mesenteric artery</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>General arteriosclerosis severe</u> DUE TO (c) <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> to <u>12/18</u> , 19 <u>61</u> , that (H) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>61</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Hugh Drey</u> 22c. PHYSICIAN'S NAME (Type) <u>Hugh Drey</u>		22b. DATE SIGNED 22d. ADDRESS <u>7105 Riggs Rd Lewisdale Hyattsville P.O. Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Wash D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co.</u> ADDRESS <u>3655 Sa Ave Sil Sprg Ind.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b <b>57 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <del>xxx</del> Country: <b>Tunisia</b>		b. COUNTY <b>Tunis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>No Street Address</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ibrahim</b>		First		Middle <b>None</b>		Last <b>Fanon</b>		4. DATE OF DEATH Month <b>December 6,</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 20, 1925</b>		9. AGE (In years last birthday) <b>36</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Indies</b>		12. CITIZEN OF WHAT COUNTRY? <b>Algeria</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>days</b>	
13. FATHER'S NAME <b>Casimir Fanon</b>		14. MOTHER'S MAIDEN NAME <b>Eleanora Medlice</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia with Pulmonary Congestion</b> <b>204.3</b> DUE TO <b>Bilateral. Pleural Effusion, Bilateral.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>10 Weeks</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>16 Rue du Dr Brunet, Tunis</b>		(County) <b>Tunis</b>	
20g. (State) <b>Tunis</b>		21. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1961</b> to <b>December 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 6, 1961</b> , and that death occurred <b>3:00pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. David Heywood</b> M.D.		22b. DATE SIGNED <b>12-7-61</b>		22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22e. REC'D BY REGISTRAR <b>DEC 13 '61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 12/9/61</b>		23b. DATE THEREOF <b>12/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Algerian Mission</b>		23d. LOCATION (City, town or county) <b>16 Rue du Dr Brunet, Tunis</b>		23e. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. ADDRESS <b>Bethesda, Maryland</b>		24b. REC'D BY REGISTRAR <b>DEC 13 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>		24d. DATE <b>DEC 13 '61</b>	

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Robert A. Ruppberg, Bethesda, Maryland  
Bureau - Bureau 12/9/61  
J. David Haywood, Jr.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>202 South Hampton Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Mr. Alexander Gordon Fant</b>		4. DATE OF DEATH <b>December 19, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1912</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>49</b>	
11. IF UNDER 24 HRS. Hours Min. <b>49</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Alexander John Fant</b>		14. MOTHER'S MAIDEN NAME <b>Helen Schroat HARENBERG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>RUTH K FANT</b>		Address <b>202 S. Hampton Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brosch</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>		DATE SIGNED <b>12-19-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR <b>Deal Funeral Home</b>		ADDRESS <b>4812 Ga. Ave., N.W., Wash. DC</b>	
24a. REC'D BY REGISTRAR <b>DEC 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>John P. Hume</b>	

23





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14099					14067				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Montgomery</b> MARYLAND					a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>				
c. LENGTH OF STAY IN 1b <b>75 Days</b>					d. STREET ADDRESS <b>1330 Monterey Avenue</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>NANCY ANN FARLEY</b>					4. DATE OF DEATH <b>December 11, 1961</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					8. DATE OF BIRTH <b>September 26, 1934</b>				
9. AGE (In years last birthday) <b>27 yrs.</b>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Secretarial</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Spencer E. Kipp</b>					14. MOTHER'S MAIDEN NAME <b>Erma Staggs</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>229-42-4873</b>				
17. INFORMANT <b>The Medical Record</b>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypoplastic Anemia</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>293X</b>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>13 hours</b> <b>10 months</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 27, 1961</b> to <b>December 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1961</b> and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above.					22a. SIGNATURE <b>Russell R. Moores</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>RUSSELL R. MOORES, M.D.</b>				
22b. DATE SIGNED <b>12-12-61</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>					23b. DATE THEREOF <b>12-12-61</b>				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State) <b>NORFOLK, VIRGINIA</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Wells - Wash D.C.</b>					25a. REC'D BY REGISTRAR <b>DEC 15 '61</b>				
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thayer</b>									

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1488

1488

Postgraduate

Virginia

October

September

1948

October

The University Center

1330 University Avenue

WASH

AND

UNIVERSITY

October 11, 1948

Female White

x September 26, 1948

Secretary

Secretary

Michigan

U.S.A.

Spencer, S. W.

John S. Jones

322-12-1073 The University Center, University of Michigan, Ann Arbor, Michigan

Inter-University

Inter-University

Dec. 11, 1948

Sept. 11, 1948

The University Center, University of Michigan, Ann Arbor, Michigan

Harvard University

Harvard University

## CERTIFICATE OF DEATH

Reg. Dist. No. 14068

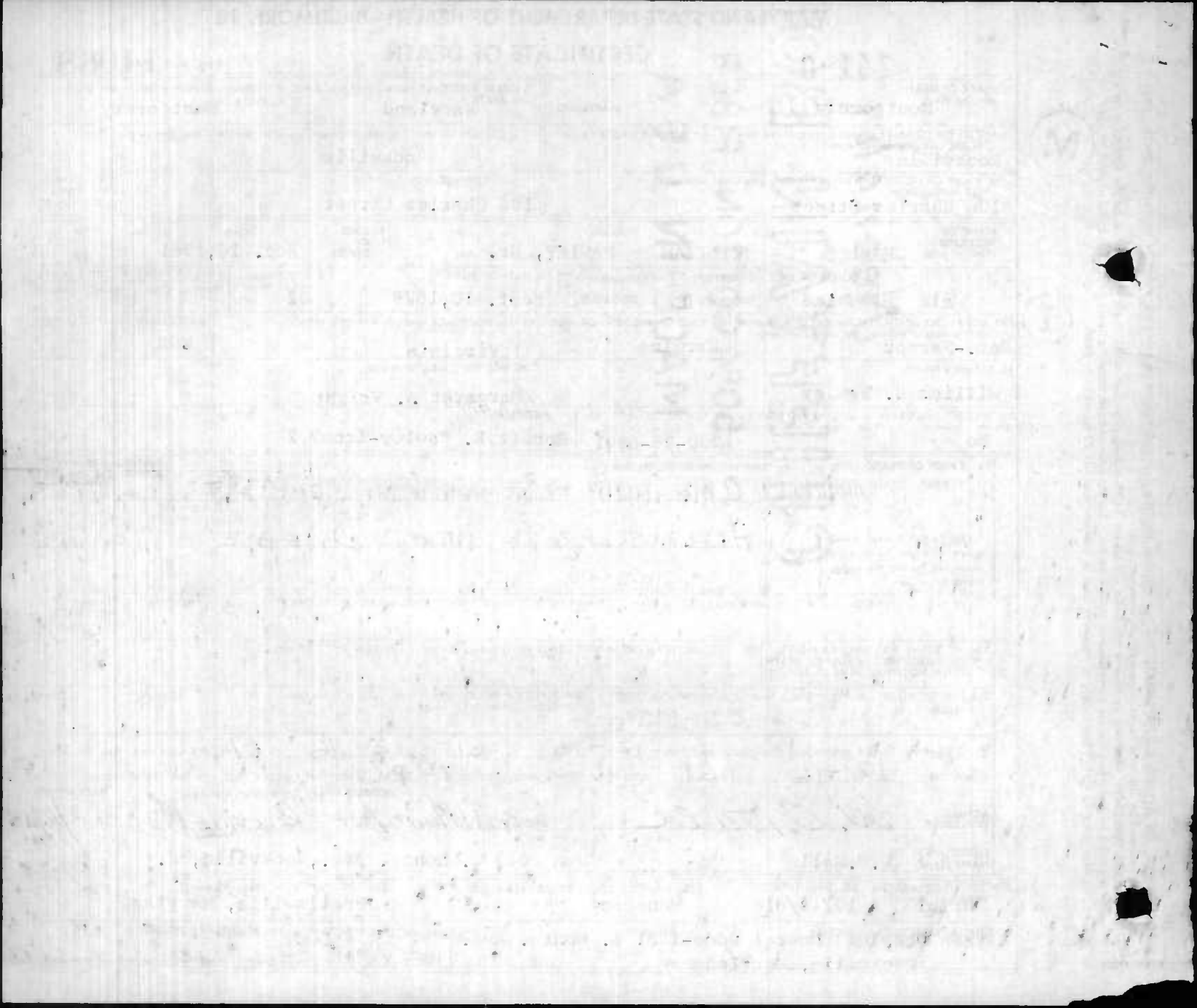
14100

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Charles Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>WILLIAM</b> Middle <b>FAWLEY, Sr.</b> Last				4. DATE OF DEATH <b>Dec. 16, 1961</b> Month <b>19</b> Day Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1879</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William B. Fawley</b>				14. MOTHER'S MAIDEN NAME <b>Margaret A. Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-26-6841</b>		INFORMANT <b>Robert B. Fawley-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASES</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ARTEROSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 MOS.</b> <b>10 YRS.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>12-16</b> , 19 <b>61</b> , to <b>12-16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>12-16</b> , 19 <b>61</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>615 W. Montg. Ave. Rockville, Md.</b> DATE SIGNED <b>12/16/61</b>							
ACTUAL SIGNATURE <b>W.G. Hall</b>		M.D. <b>C. S. W. MONTG. AVE. ROCKVILLE, MD.</b>					
PHYSICIAN'S NAME (Type) <b>W.G. Hall</b>		615 W. Montg. Ave., Rockville, Md.					
22a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 20 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and the funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. ☒ Completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14069

Items 9 & 23b Film G304 12/29/61 mh

1. PLACE OF DEATH MONTGOMERY 14101		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE N. C. b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TARAWA TARRACE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3389 HAGARU DR.	
3. NAME OF DECEASED (Type or print) JOSEPHINE PATRICA FELLOWS		4. DATE OF DEATH DECEMBER 16 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 DECEMBER 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) ILLINOIS	
13. FATHER'S NAME WALTER WALSH		14. MOTHER'S MAIDEN NAME HELENE PORZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband: Robert Fellows, same as #3		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - Asphyxiation</i> DUE TO (b) <i>Metastatic Carcinoma of Cerv</i> DUE TO (c) <i>General Debilitation</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 months	
21. I certify that (I) (this hospital) attended the deceased from JULY 20 1961 to DECEMBER 16 1961, that (I) (we) last saw the deceased alive on DEC 16 1961, and that death occurred at 0640, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <i>Louis E. Potvin</i> M.D.		22b. DATE SIGNED 12-16-61	
22c. PHYSICIAN'S NAME (Type) LOUIS E. POTVIN, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 21, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Boniface Cemetery		23d. LOCATION (City, town or county) (State) Chicago, Ill.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR DATE DEC 21 '61	
25b. REGISTRAR'S SIGNATURE <i>Charles L. Kenna</i>			

(M)

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THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH. THE CERTIFICATE MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE THE CERTIFICATE FROM THE DEATH CERTIFICATE AND RETURN IT TO THE DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND, WITHIN 72 HOURS AFTER DEATH.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14102

## CERTIFICATE OF DEATH

14070

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 hrs - 10 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Takoma Park</u> d. STREET ADDRESS <u>6506 Highland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Allen</u> Middle <u>Fielding</u> Last		DATE OF DEATH <u>December</u> Month <u>3</u> Day <u>1961</u> Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 14, 1904</u> Yrs. <u>57</u>	
9. AGE (In years last birthday) <u>57</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Fielding</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>578-01-7983</u>		16. SOCIAL SECURITY NO. <u>578-01-7983</u>	
17. INFORMANT <u>Hospital Record.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this Hospital) attended the deceased from <u>Feb 3, 1961</u> to <u>Dec 3, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec 3, 1961</u> and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Boris Rabin</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>	
22b. DATE SIGNED <u>December 4, 1961</u>		22d. ADDRESS <u>1019 University Blvd, East Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 6, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14103

## CERTIFICATE OF DEATH

14071

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>40 Silver Spring</u> d. STREET ADDRESS <u>19819 Rosesteel Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clyde William Fiery</u>		<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>10</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1/9/183</u> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>18</u> <b>11. IF UNDER 24 HRS.</b> Hours <u>18</u> Min. <u>78</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrical engineer Govt.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Albert Fiery</u> <b>14. MOTHER'S MARRIED NAME</b> <u>Kathryn ? Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>Elizabeth Loggins / Silver Sp. Ave.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive heart failure</u> DUE TO (b) <u>Myocardial hypertrophy</u> (c) <u>Generalized atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>no</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>12</u> p.m. <u>30</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 1955</u> , to <u>12-10</u> , 19 <u>61</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>12-9</u> , 19 <u>61</u> , and that death occurred at <u>308</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Seruth T. Kimble</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Seruth T. Kimble</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>927 Pershing Drive Silver Spring, Md.</u>		<b>22b. DATE SIGNED</b> <u>DEC 14 '61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>12/13/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PROSPECT HILL CEMETERY</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>WASHINGTON D.C.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 14 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kimble</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										14072	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>39 Silver Spring</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>						d. STREET ADDRESS <b>2100 Reddie Drive</b>					
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Figelman</b> Last <b>Figelman</b>						4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/6/07</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Economist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Foreign Commerce</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Figelman</b>						14. MOTHER'S MAIDEN NAME <b>Ethel Cohen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218389519</b>		17. INFORMANT Address <b>Sophie Figelman-2100 Reddie Dr., SS, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Thrombosis, left coronary artery</b> DUE TO (c) <b>Coronary Atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b> <b>Unknown</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>12-8-61</b>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				DATE SIGNED <b>12-8-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B ural</b>		22b. DATE THEREOF <b>12-10-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Montefiore Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Pinelawn, New York</b>			
23. FUNERAL DIRECTOR ADDRESS <b>Bernard Danzansky &amp; Sons-3501 14th St.-NW</b>						24a. REC'D BY REGISTRAR <b>DEC 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14073

14105

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>olney</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville,</b> d. STREET ADDRESS <b>200 S Horners Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RAYMOND CLAY FISHER</b>			4. DATE OF DEATH Month <b>12-</b> Day <b>22</b> Year <b>19 61</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-05</b>		9. AGE (In years last birthday) <b>56</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>service sta. attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Nathaniel Clay Fisher</b>			14. MOTHER'S MAIDEN NAME <b>Cora Mc Gaha</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes give number and date of service) <b>217-03-4612</b>	17. INFORMANT <b>Hospital records</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROSIS</b> DUE TO (c) <b>ARTERIAL HYPERTENSION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>30 HOURS</b> <b>10 YEARS</b> <b>10 YEARS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>NEPHROSCLEROSIS - RENAL FAILURE</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>21 DEC 1961</b> to <b>22 DEC 1961</b> , that (I) (we) last saw the deceased alive on <b>22 DEC 1961</b> , and that death occurred <b>8 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Gordon S. Rosenberger</i> Gordon S. Rosenberger			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>316 W. MONTGOMERY AVE ROCKVILLE, MARYLAND</b>		22b. DATE SIGNED <b>22 DEC 1961</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/26/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Meth. Ch. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Potomac, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Montgomery

Montgomery

Montgomery

Olney

Olney

Olney

Montgomery General Hospital

200 & Holmes Lane

RAYMOND

CLAY

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Male

White

8-24-05

55

service esp. attendance at

Montgomery

Raymond Clay Fisher

Cole No 622

Raymond

Hospital records

Raymond Clay Fisher

Raymond Clay Fisher

Raymond Clay Fisher

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Raymond Clay Fisher

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

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X									
I									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					c. LENGTH OF STAY IN 1b <b>24</b> <b>Silver Spring</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>721 Thayer Avenue</b>					d. STREET ADDRESS <b>721 Thayer Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Howard Sturdevant Fisk</b>					4. DATE OF DEATH <b>December 20 1961</b>				
5. SEX <b>male</b>					6. COLOR OR RACE <b>white</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>2/1/78</b>				
9. AGE (In years last birthday) <b>83</b>					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Star Newspaper Reporter</b>					11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Henry Clay Fisk</b>					14. MOTHER'S MAIDEN NAME <b>Emma Jane Nutt</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>					16. SOCIAL SECURITY NO. <b>?</b>				
17. INFORMANT <b>Katherine Fisk Bartley</b>					Address <b>same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROSIS</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>November 16, 1961</b> to <b>December 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 18, 1961</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Theodore J. Abennethy</b> M.D.									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>Theodore J. Abennethy</b>									
22d. ADDRESS <b>1834 Eye St. N.W. Washington 6. D.C.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>									
23b. DATE THEREOF <b>12/22/61</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery Washington, D.C.</b>									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b> ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>									
25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>									
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									

1904

1902

Montgomery

Silver Spring

1217 Star Avenue

Hand 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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Hand 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Hand 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Hand 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Yes

Company 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Anterior 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

December 10, 1901

James I. Adams  
Theodore I. Adams

12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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1234 56 78 90 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

2001 1234 56 78 90 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

The S. R. Hines Company  
Washington, D.C.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14107

14075

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>16 da</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda 54</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>				d. STREET ADDRESS <i>4111 Leland St</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Wilson</i> Last <i>Flournoy</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>6</i> Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20th 1878</i>		9. AGE (In years lost birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Park Flournoy</i>				14. MOTHER'S MAIDEN NAME <i>Mary Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Addison H. Flournoy</i>		Address <i>4111 Leland St. Bethesda, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4 Cerebral Embolism</i> DUE TO (b) <i>Cardiac Irregularity</i> DUE TO (c) <i>Old Age</i>							INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>NONE DETERMINED</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>Jan 1940</i> to <i>Dec 6 1961</i> , that (I) <del>(was)</del> last saw the deceased alive on <i>Dec 5 1961</i> and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Bradley D. Hodgkins</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Dec 6, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>BRADLEY D. HODGKINS</i>				22d. ADDRESS <i>4413 Bradley Lane</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12/7/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>DEC 7 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

1107

CHRONICLE OF DATH

1107

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14108

CERTIFICATE OF DEATH

Reg. Dist. No. 14076

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San and Hospital</u>				d. STREET ADDRESS <u>6010 Broad Branch Rd. NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Evelyn Susan Foresman</u>				4. DATE OF DEATH Month Day Year <u>12 19 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-98</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Economist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr. cafeterias</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Bond</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		INFORMANT Address <u>Hospital chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation-Rt Hrt Failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>Hypertensive Cardio-Renal Complex</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>3 weeks</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-19-</u> , 19 <u>61</u> , to <u>12-19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>61</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, 12/19/61</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>				DATE SIGNED <u>12/19/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>12/22/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

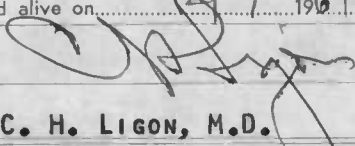
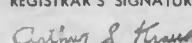
10108

OFFICE OF THE SECRETARY OF THE ARMY

10108



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN IB <b>17 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>ALFRED LLOYD FRALEY</b>		First Middle Last	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-26-93</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(RETIRED) MECHANIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fraley</b>		14. MOTHER'S MAIDEN NAME <b>Hinda Adamson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no unk.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA.</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ADENOCARCINOMA OF STOMACH WITH METASTASIS TO</b> DUE TO (c) <b>THE DIAPHRAGM.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>- 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>8450 12/7/61</b>	
21. I certify that I (this hospital) attended the deceased from..... to....., that I (we) last saw the deceased alive on....., and that death occurred at..... M, from the causes and on the date stated above			
22a. SIGNATURE 		22b. DATE SIGNED <b>12/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-11-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Lutheran</b>		23d. LOCATION (City, town or county) (State) <b>Redland Mont. Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Maryland</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 13 '61</b>		25b. REGISTRAR'S SIGNATURE 	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
1SM 9/60



1109

Box 22

18-10-22

hospital records

DEPARTMENT OF HEALTH WITH REFERENCE TO

THE STAFF

JAMES SPRING, HARTFORD

C. H. LIND, M.D.

HARTFORD, CONN.

HARTFORD, CONN.

HARTFORD, CONN.

1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14110

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14078

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>10 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (rural)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8 Russell Ave., Drs. office</b>				d. STREET ADDRESS <b>Metropolitan Grove</b>			
3. NAME OF DECEASED (Type or print) <b>Charles F Frazier</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/ 12/1899</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cy Frazier</b>				14. MOTHER'S MAIDEN NAME <b>Mary Noland</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>M.C. Police</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>022X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Rupture of aortic aneurysm into</b> DUE TO (c) <b>large bronchus of lung st</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/5/61</b> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D.					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Rose.,</b>		22d. LOCATION (City, town, or county) (State) <b>Cloppers, Md.</b>	
23. FUNERAL DIRECTOR <b>Robert L. Swowder</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 Medical Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/1/51

11/1/51



1/3/51

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1/3/51



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

14111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14079

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>12 Kensington</b> d. STREET ADDRESS <b>1 5209 Gretchen St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Deborah Lynn Gabriel</b>				4. DATE OF DEATH <b>December 21, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/7/58</b>	
9. AGE (In years last birthday) <b>3 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Roger P. Gabriel</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Trumpp</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>[blank]</b>			
17. INFORMANT <b>Hosp Record</b>				Address <b>[blank]</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>1st, 2nd + 3rd degree burns involving about 80% of body</b> DUE TO (c) <b>[blank]</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>[blank]</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothes caught on fire - playing with cigarette lighter</b>			
20c. TIME OF INJURY Month, Day, Year <b>9:02 am 12-21-1961</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) <b>Kensington</b> (County) <b>Montgomery</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschaw</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschaw</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-23-1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Rockville, Md.</b>			
23. FUNERAL DIRECTOR <b>Joseph L. Davis, Inc.</b>				24. REC'D BY REGISTRAR <b>DEC 26 '61</b>			
ADDRESS <b>1756 Pa Ave NW, Wash DC</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

1111 MEDICAL EXAMINATION REPORT

DATE: 10-27-1961

EXAMINER: [illegible]

LOCATION: [illegible]

REASON FOR EXAMINATION: [illegible]

PHYSICAL EXAMINATION: [illegible]

LABORATORY TESTS: [illegible]

RESULTS: [illegible]

DISCUSSION: [illegible]

CONCLUSION: [illegible]

SIGNATURE: [illegible]

DATE: 10-27-1961

LOCATION: [illegible]

REASON FOR EXAMINATION: [illegible]

PHYSICAL EXAMINATION: [illegible]

LABORATORY TESTS: [illegible]

RESULTS: [illegible]

DISCUSSION: [illegible]

CONCLUSION: [illegible]

SIGNATURE: [illegible]

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14112

## CERTIFICATE OF DEATH

14080

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN it <u>15 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13 Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16550 Emory Lane</u>				d. STREET ADDRESS <u>16550 Emory Lane</u>			
3. NAME OF DECEASED (Type or print) <u>JESSIE LORETTA GAUL</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1879</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTH PLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William James Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Ellen O'Brien</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs Katherine Mather 16550 Emory Lane Rockville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerosis, generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>Yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 12/20</u> to <u>12/22/61</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/22/61</u>
22c. PHYSICIAN'S NAME (Type) <u>C.H. H. [Signature]</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, or other disposal (State city) <u>Removal</u>		23b. DATE THEREOF <u>Dec. 26 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Park</u>		23d. LOCATION (City, town or county) (State) <u>Hackensack New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 29 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the funeral director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the funeral director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

141113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14081

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 Hour 40 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>14105 Chelmsford Road</u>			
3. NAME OF DECEASED (Type or print) <u>Lillian</u> <u>MMN</u> <u>Geatt</u>				4. DATE OF DEATH <u>December 31, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1923</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Morris Brenner</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Washington Sanitarium + Hospital Records</u>				Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 4-29-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <u>  </u>				DATE SIGNED <u>12-31-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JAN 2-1962</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM</u>				22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY CO PENN</u>			
23. FUNERAL DIRECTOR <u>B Danyansky &amp; Sons</u>				24a. REC'D BY REGISTRAR <u>  </u>			
ADDRESS <u>3501-46 ST NW</u>				24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>			
DATE <u>JAN 4 '62</u>							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File #305 1/8/62

## CERTIFICATE OF DEATH

Reg. Dist. No. 14082

14114

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Silver Spring Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bel Pre Sanitarium</b>				d. STREET ADDRESS <b>5000 Aberdeen Rd.</b> <b>Boy/Pls Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SIMON</b> Middle <b>GERBER</b> Last				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 6, 1882</b>		9. AGE (In years lost birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist-Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Maurice B. Miller Bethesda, Maryland</b> <b>8000 Aberdeen Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>42000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 day</b> <b>18 months</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/19, 1961</b> to <b>12/31, 1961</b> , that I last saw the deceased alive on <b>12/30, 1961</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3900 McKenley St. NW</b> DATE SIGNED <b>12/31/61</b>							
ACTUAL SIGNATURE <b>Irving W. Winik</b>		M.D. <b>3900 McKenley St. NW</b>					
PHYSICIAN'S NAME (Type) <b>Irving W. Winik</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons</b>				ADDRESS <b>3501 14th St. NW</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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OFFICE OF THE ASSISTANT SECRETARY  
FOR AGRICULTURAL MARKETING  
DIVISION OF MARKET ECONOMICS  
UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]  
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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 of the State Board of Health, should be retained for your files. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14083

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mon</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>50 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		d. STREET ADDRESS <u>6912 Silver Locks Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence E Gibbs</u>				4. DATE OF DEATH <u>12-12-1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD GIBBS</u>				14. MOTHER'S MAIDEN NAME <u>ODELIA JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-0128195</u>		17. INFORMANT <u>Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } (c) }						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous heart disease</u>							
20a. EXTERNAL CAUSE, WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/16/1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Cabin John, Maryland</u>			
23. FUNERAL DIRECTOR <u>John R. Asher</u>				24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>			
W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14116

14084

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>704 Gilbert Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Walter William Gorton</b>				4. DATE OF DEATH <b>December 5 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 5, 1909</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Sub. Sanitary Commission</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry R. Gorton</b>			14. MOTHER'S MAIDEN NAME <b>Dora Simmons</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Yes, UN</b>		17. INFORMANT <b>Washington Sanitarium and Hospital Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung &amp; metastases</b> 163X Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this Hospital) attended the deceased from <b>Dec. 5, 1961</b> to <b>Dec. 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 14, 1961</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Abraham W. Davis</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-15-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DAVIS</b>		22d. ADDRESS <b>1106 SPRING ST. Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE THEREOF <b>Dec. 18, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Inc.</b>		ADDRESS <b>8655 G.D. Ave. Silver Spring Md</b>		25a. REC'D BY REGISTRAR <b>DEC 18 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14117

## CERTIFICATE OF DEATH

14085

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>24 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Kensington</b>		d. STREET ADDRESS <b>3822 Lawrence Ave,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha A Gittings</b>				4. DATE OF DEATH Month Day Year <b>Dec. 24, 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1890</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James A. Gordon</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Melvin Roderick(son)</b>				3809 Decatur Ave. <b>Kensington, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>At. failure c shock</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs.</b> <b>sevl. pro.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/23, 1961</b> to <b>12/24, 1961</b> , that (I) (we) last saw the deceased alive on <b>12/24, 1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Marvin Wadler</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>MARVIN WADLER</b>				22d. ADDRESS <b>8218 WISCONSIN AV. BETH. MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brownsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25. REC'D BY REGISTRAR <b>DEC 28 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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ROBERT A. KENNEDY, JR.  
19-37-61  
Brownsville Cemetery  
Brownsville, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14118

## CERTIFICATE OF DEATH

14086

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN bldg. <u>6 1/2 hrs</u>				d. STREET ADDRESS <u>1407 Wheaton Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>McKinley</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10, 1917</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ferguson Green</u>				14. MOTHER'S MAIDEN NAME <u>Earline Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War II</u>				16. SOCIAL SECURITY NO. <u>4013 Plym Miller</u>			
17. INFORMANT <u>Estelle Jane Green (wife)</u>				Address <u>Kensington Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Respiratory insufficiency</u> 527.2 DUE TO (b) <u>Pulmonary Edema</u> (c) <u>Mucoid obstruction of Bronchi</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/18/61</u> , 19 <u>61</u> , to <u>12/19/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/19/61</u> , 19 <u>61</u> , and that death occurred <u>12:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Witowski, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Witowski, Jr.</u>				22d. ADDRESS <u>SUITE 400, 8218 WISCONSIN AVE. BETHESDA 14, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Snowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
14119													
14087													
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney						c. LENGTH OF STAY IN 1b 53 days							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital						d. STREET ADDRESS Rt. Box 226							
3. NAME OF DECEASED (Type or print) First Middle Last Francis Charles Green						4. DATE OF DEATH Month Day Year 12 2 19 61							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/28/1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Irvin Green						14. MOTHER'S MAIDEN NAME Harriett Lafsnider							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ACUTE MYOCARDIAL INFARCTION (c) CORONARY ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Diabetes Mellitus										INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-10-1961 to 12-2-1961, that (I) (we) last saw the deceased alive on 12-2-1961, and that death occurred at 6:45 p.m. from the causes and on the date stated above.													
22a. SIGNATURE Jack Schumacher M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12-3-61				
22c. PHYSICIAN'S NAME (Type) Jack Schumacher						22d. ADDRESS Gaithersburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 12-4-61		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln				23d. LOCATION (City, town or county) (State) Bladensburg, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner						25a. REC'D BY REGISTRAR DATE DEC 5 '61						25b. REGISTRAR'S SIGNATURE Charles L. Thomas	

(M)

ACUTE MYOCARDIAL INFARCTION  
CORONARY ATHEROSCLEROSIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
14120 <b>CERTIFICATE OF DEATH</b> 14088													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>						d. STREET ADDRESS <b>3704 Macomb Street NW</b>							
3. NAME OF DECEASED (Type or print) First <b>James Edward</b> Middle <b>Male</b> Last <b>Greene</b>						4. DATE OF DEATH Month <b>Dec</b> Day <b>13</b> Year <b>1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 13, 1961</b>		9. AGE (In years last birthday) yrs. <b>3</b> Months <b>50</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <b>3</b> Min. <b>50</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				
13. FATHER'S NAME <b>John William (Unknown) Greene</b>						14. MOTHER'S MAIDEN NAME <b>Nattalie Patricia Griffith</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.			17. INFORMANT <b>(Hospital Record.)</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>760.0</b> DUE TO <b>Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <b>Subarachnoidal hemorrhage</b> DUE TO <b>Birth trauma</b>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>13 Dec</b> , 19 <b>61</b> to <b>13 Dec</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>13 Dec</b> , 19 <b>61</b> , and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>RH Mitchell</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>18 Dec 61</b>				
22c. PHYSICIAN'S NAME (Type) <b>RH MITCHELL MD</b>						22d. ADDRESS <b>8218 Wisconsin Ave Bethesda Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>				
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey,</b> ADDRESS <b>Bethesda, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				

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West

to the

Sanitary

Infant

Plate

(Engraving) - Green

11120

to the

Sanitary

Infant

Plate

Mineral

(Engraving) - Green

11120

to the

Plate

Rockville, Maryland

12-26-01, Perkins Cemetery

Engraving

Robert A. Humphrey, Bedford, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14121

14089

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Kensington</u> d. STREET ADDRESS <u>1 4821 Flanders Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Victoria (No middle name) Gruver</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>December 24 19 61</u> Month Day Year							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5 April 1894</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self employed</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Daniel Gruver</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Schnee</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Not available</u>		<b>17. INFORMANT</b> <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Md.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 1969 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>OSTEOGENIC SARCOMA WITH</u> (c) <u>PULMONARY METASTASIS</u> (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>2Dc. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>2Dd. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>2De. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify</b> that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 15 1961</u> to <u>December 24 19 61</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 24 19 61</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>J. Kent Trinkle, M.D.</u>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>December 25, 1961</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. Kent Trinkle, M.D.</u>				<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit</u>				<b>23b. DATE THEREOF</b> <u>12-25-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Hanover Township, Penna.</u> (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>ADDRESS</b> <u>Bethesda, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 28 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

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PULMONARY METASTASIS  
OSTEOGENIC SARCOMA WITH  
CARDIORESPIRATORY ARREST

Robert A. Farquhar

St. Mary's Cemetery, Hanover Township, Penna.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14122  
CERTIFICATE OF DEATH  
14090

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>NB</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LISA</u> First <u>MARIE</u> Middle <u>GUARDINO</u> Last		4. DATE OF DEATH <u>December 7</u> 19 <u>61</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 6, 1961</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>25</u> Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH JOHN GUARDINO</u>		14. MOTHER'S MAIDEN NAME <u>MAUREEN AGNES CLARK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>broncho pneumonia</u> 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>premature</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>61</u> , to <u>12/7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/7 8:30 AM</u> 19 <u>61</u> , and that death occurred at <u>12:25</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Vita R. Jaffe</u>		22b. DATE SIGNED <u>12/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAFFE, Vita R</u>		22d. ADDRESS <u>5079 Brady Blvd Chelmsbury</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>12-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town or county) (State) <u>BETHESDA - MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER ADMIN. - SUBURBAN HOSPITAL</u> ADDRESS <u>(per F-1B)</u>		25a. REC'D BY REGISTRAR <u>DEC 12 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14123

## CERTIFICATE OF DEATH

Item 21 Film G303 12/21/61 iwk

14092

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>34 Wheaton, Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				d. STREET ADDRESS <i>12706 Valleywood Drive</i>			
3. NAME OF DECEASED (Type or print) First <i>Ruth</i> Middle <i>Andrea</i> Last <i>Hall</i>				4. DATE OF DEATH Month <i>12</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-08</i>	
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Kazey Illinois</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Hugh A Warman</i>				14. MOTHER'S MAIDEN NAME <i>Wava Wood</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>163-14-3309</i>			
17. INFORMANT <i>Arthur R Hall</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>491X</i> DUE TO Confluent bronchopneumonia, lobar, <i>acute</i> Tense, multilobar DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Hypertensive cardiovascular disease with coronary atherosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Several days</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> a.m. <i>19</i> p.m.		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> to <i>NOV 2</i> , 1961, that (I) <i>(no)</i> last saw the deceased alive on <i>December 1</i> , 1961, and that death occurred at <i>1200</i> M, from the causes and on the date stated above.				22a. SIGNATURE <i>P. L. Tabb, M.D.</i> M.D.			
22c. PHYSICIAN'S NAME (Type) <i>S. L. TABB, M.D.</i>				22b. DATE SIGNED <i>Dec 11/1/61</i>			
22d. ADDRESS <i>13,000 GEORGIA AVE S. L. T. MD.</i>				22e. REC'D BY REGISTRAR <i>DEC 6 '61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i>		23b. DATE THEREOF <i>12-2-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Valley Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Allegheny County, Penna.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>				25. REGISTRAR'S SIGNATURE <i>Arthur R. Hall</i>			

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

13,000 Georgia Ave 2.1. P. M.  
11/10/01  
P. L. Jones, esq.  
2 L. TACK, M.D.  
Nov 1 01  
per 1300  
to Nov 2 01

ROBERT A. HUBBARD  
Notary Public  
Notary Public  
Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14124

CERTIFICATE OF DEATH

14093

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Pennsylvania</u> b. COUNTY <u>Cumberland</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shippensburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Star Route 2</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Walter Stewart Hall</u>				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>11</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>November 1, 1899</u>	
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Hall</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Winters</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unascertainable</u>			
<b>17. INFORMANT</b> <u>The Medical Record</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Probable clostridial septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gas gangrene of scrotum and perineum</u> DUE TO (c) <u>Chronic lymphocytic leukemia</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>? 6-8 hours</u> <u>? 1 Day</u> <u>6 Months</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 31, 1961</u> , to <u>December 11, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 11, 1961</u> , and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Edward S. Henderson</u> M.D.				<b>22b. DATE SIGNED</b> <u>12-11-61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Edward S. Henderson M.D.</u>				<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION (City, town or county) (State)</b>	
<u>Burial-Transit</u>		<u>12/12/61</u>		<u>Spring Hill Cemetery</u>		<u>Shippensburg, Penna.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DEC 15 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thoms</u>							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
14125  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

Item 23b, Film G305 1/10/62 iwk

14094

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia		b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Bethesda		c. LENGTH OF STAY in 1b 1 Day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL				d. STREET ADDRESS 2015 Newton St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Timothy Allen		First Middle Last Hamilton		4. DATE OF DEATH December 18 19 61		Month Day Year	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 December 1961	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George Hamilton				14. MOTHER'S MAIDEN NAME Evelyn Hamilton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X PREMATUREITY DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Dec. 17, 1961, to Dec. 18, 1961, that (1) (we) last saw the deceased alive on Dec. 18, 1961, and that death occurred at 3:10 AM from the causes and on the date stated above.							
22a. SIGNATURE Bernard H. Feldman				M.D.		22b. DATE SIGNED December 19, 1961	
22c. PHYSICIAN'S NAME (Type) BERNARD H. FELDMAN LT MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/22/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.				ADDRESS D.C. 3rd St. SW, Washington		25a. REC'D BY REGISTRAR DATE DEC 26 '61	
						25b. REGISTRAR'S SIGNATURE C. S. Thomas	

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1932

SECRET

1931



## CERTIFICATE OF DEATH

Reg. Dist. No. 14095

14126

1. PLACE OF DEATH a. <b>Montgomery</b> <b>Silver Spring</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write <b>Silver Spring</b> ) c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Silver Springs</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>762 Silver Spring Ave</b>			d. STREET ADDRESS <b>762 Silver Springs Ave</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>J</b> Last <b>Hayden</b>			4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19. 1874</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Elisha K Hayden</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Williams</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Daughter</b>		Address <b>Mrs. Eva May Garrison 762 Silver Springs Ave S. S. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>5 da</b> <b>years.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Dec</b>	(County) <b>1961</b>	(State) <b>1961</b>
21. I certify that I attended the deceased from <b>April</b> , 19 <b>61</b> , to <b>Dec</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Dec 3</b> , 19 <b>61</b> , and that death occurred at <b>5:59 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4501 Conn. Ave. N.W.</b> DATE SIGNED <b>12/4/61</b> ACTUAL SIGNATURE <b>Robert S. Poole</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert S. Poole</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/6/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Washington, D. C.</b> <b>W. K. Muntemann &amp; Son</b>			24a. REC'D BY REGISTRAR <b>DEC 6 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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 2. *Chrysomelidae*

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FOR STATE  
HEALTH DEPT. **M**  
74  
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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14127  
14096  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>1 day-9hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4616 Sleaford Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>E.</b> Last <b>Hellback</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>		IF UNDER 24 HRS. Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert Zorn</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Winkelman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>(Paula Fowler) daughter</b> Address <b>same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> 274X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiorespiratory Failure</b> DUE TO (c) <b>Abdominal Insufficiency - Metastatic Carcinoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>14 hours Status Postoperative - Nailing Rt Femur</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor at home - Fracture rt hip</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:00 p.m. 12-21 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Bethesda</b> (County) <b>montg</b> (State) <b>md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE <b>Frank J. Broschant</b> M.D.							DATE SIGNED <b>12-23-61</b>
DEPUTY MEDICAL EXAMINER <b>FRANK J. Broschant</b> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Rockville Md.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Raymond A. Ziska</b> <b>Warner E. Pumphrey, Inc.</b>				24a. REC'D BY REGISTRAR <b>DEC 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14128

14097

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - RFD</u> c. LENGTH OF STAY IN lb <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - RFD</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Edward Osborne Henderson</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec 10 1961</u>					
<b>5. SEX</b> <u>M -</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 5 - 1876</u>			
<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm - hater</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>									
<b>13. FATHER'S NAME</b> <u>Edward C. Henderson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Susana E. Thompson</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Mrs Leo Clagett, Clarksburg-Md RFD</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Senile</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Four years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 1957</u> <b>to</b> <u>12-10</u> , 1961, that (I) (we) last saw the deceased alive on <u>Sept. 14 1961</u> , and that death occurred <u>10:45</u> A.M., from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Jack Schumacher</u>				<b>22b. DATE SIGNED</b> <u>12-11-61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JACK SCHUMACHER</u>				<b>22d. ADDRESS</b> <u>GAITHERSBURG M.D.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/12/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Rockville, Md</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William B. Helton, Baltimore, Md</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 18 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

①

Received of the Treasurer of the  
Board of Education the sum of \$100.00  
for the purchase of books for the  
School of the City of New York.

Witness my hand and seal this 10th day of  
January, 1872.

John C. Hendon  
Treasurer of the Board of Education

Attest:  
John C. Hendon  
Treasurer of the Board of Education

John C. Hendon  
Treasurer of the Board of Education

John C. Hendon  
Treasurer of the Board of Education

John C. Hendon  
Treasurer of the Board of Education

John C. Hendon  
Treasurer of the Board of Education

John C. Hendon  
Treasurer of the Board of Education



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14129

14098

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>123 S. Adams Street</b>		d. STREET ADDRESS <b>123 S. Adams Street</b>	
3. NAME OF DECEASED (Type or print) <b>LAVINIA DAWSON HENDERSON</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Rockville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Thomas Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Peter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-38-3122B</b>	
17. INFORMANT <b>Son</b>		Address <b>Joseph Henderson Same as #2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20-1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>coronary insufficiency</b> (c) <b>arteriosclerotic cardiovascular disease</b> cause last. <b>5 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 years</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 25, 1957</b> to <b>Dec. 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1961</b> , and that death occurred at <b>4:31 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen C. Cromwell</b> M.D.		22b. DATE SIGNED <b>Dec. 28, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN C. CROMWELL, JR.</b>		22d. ADDRESS <b>615 W. Montgomery Ave, Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Jan 2 '62</b>		25c. REGISTRAR'S SIGNATURE <b>C. S. Hanna</b>	



1913

1913

1913

Montgomery

Montgomery

Montgomery

Rockville

Rockville

123 N. Adams Street

123 N. Adams Street

LAVINIA

WENDERSKY

Dec. 25

Female

Dec. 1, 1900

Dec. 15

Rockville

Rockville, Maryland

THOMAS DAWSON

Mrs. Alice Peter

SON

Same, ne 23

21-25-21 Joseph Henderson

Dec. 25, 1913

STEWART A. BROWN, JR., 615 N. Montgomery Ave., Rockville, Md.

Rockville, Maryland

Rockville, Maryland

12-30-1

Male

ROBERT A. BROWN

Beltsville, Md.

JAN 5, 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14130

## CERTIFICATE OF DEATH

14099

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>53 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1503 Stirling Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stanley S. Henderson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-02</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Chemist</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Franklin Edward Henderson</u>	
14. MOTHER'S MAIDEN NAME <u>Jenny Fones</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Margaret S. Henderson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>Dec 11</u> , 19 <u>61</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Dec 11</u> , 19 <u>61</u> , and that death occurred at <u>8:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u> 22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>12/11/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>345 University Blvd West, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u>
24. FURNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		25c. ADDRESS <u>8434 Georgia Avenue</u>	

14130

①

Franklin Adams Anderson

John V. Jones

175 Station Road

Westchester, N. Y.

My dear Mr. Jones:

Dear Mr. Jones:

Dear Mr. Jones:

Very truly yours,

Franklin Adams Anderson

14130

Page 1 of 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14131											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in lb <b>27 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Warren</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Front Royal</b> d. STREET ADDRESS <b>13 Cherrywood Apartments</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Agatha</b> Last <b>Henry</b>						4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29, 1921</b>		9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Carbaugh</b>						14. MOTHER'S MAIDEN NAME <b>Virginia Lemley</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>227-22-0908</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable septicemia</b> DUE TO (b) <b>Acute myelocytic leukemia with hepatomegaly (1800 grams) and splenomegaly (325 grams)</b> DUE TO (c) <b>1800 grams) and splenomegaly (325 grams)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>204.2</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>3 months</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 8, 1961</b> to <b>Dec. 5, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 5, 1961</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>J. David Heywood</b>						22b. DATE SIGNED <b>December 6, 1961</b>					
22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood, M.D.</b>						22d. ADDRESS <b>The Clinical Center, the National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>				23b. DATE THEREOF <b>12-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Front Royal, Virginia.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>	

M

11131

The Clinical Center, National Institutes of Health, Bethesda, Maryland

January 10, 1951

Dr. J. H. Brown

Department of Medicine

University of Maryland School of Medicine

300 North Wolfe Street, Baltimore 5, Maryland

Dear Dr. Brown:

Enclosed for you are two copies of a report on the results of the study of the effect of the administration of a certain drug on the clinical course of the disease.

I am sure that this information will be of interest to you.

Very truly yours,

David H. Brown, M.D.

Director, Clinical Center

National Institutes of Health

Bethesda, Maryland

Enclosed for you are two copies of a report on the results of the study of the effect of the administration of a certain drug on the clinical course of the disease.

I am sure that this information will be of interest to you.

Very truly yours,

Robert A. Thompson, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

CERTIFICATE OF DEATH

Reg. Dist. No. 14101

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>13 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ursuline Academy Forest Lane</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9900 Forest Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mother Agnes) Sarah</u> <u>Herkness</u>		4. DATE OF DEATH Month Day Year <u>December 28 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2 1879</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mother Agnes of the Ursuline Nuns</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelpha Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Herkness</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Strain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records of Ursuline Academy Bethesda 14 Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AURICULAR FIBRILLATION</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>10+ YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 MONTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NECROTIC NEPHRITIS &amp; CYSTITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D. N. A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 1954</u> to <u>12/28 1961</u> , that I last saw the deceased alive on <u>12/26 1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda</u>		DATE SIGNED <u>12/28/61</u>	
ACTUAL SIGNATURE <u>Charles J. Savarese Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Charles J. Savarese Jr. M.D. 4890 Battery Lane Bethesda 14 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/30/1961</u>		22b. DATE THEREOF <u>12/30/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Oliver</u>		22d. LOCATION (City, town, or county) (State) <u>St. Oliver D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Raffele</u> ADDRESS <u>475-H-ST. NW</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified & Approved.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
14133 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. LENGTH OF STAY IN lb <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Bethesda</b>					
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION <b>3000 McComas Ave. Kensington Gardens Sanitarium</b>					d. STREET ADDRESS <b>7816 Statford Pl.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Camille</b> Middle <b>Hindmarsh</b> Last					4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1961</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 18, 1872</b>		9. AGE (In years lost birthday) <b>89 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Edmond H. Becker</b>					14. MOTHER'S MAIDEN NAME <b>Emma Brica</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Edmund Becker-Brother-same 2d</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Rt. Pulver Bone - one week.</b>									INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell Nov. 25, 1961 at Nursing Home</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> to <b>Dec 3</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 2</b> , 19 <b>61</b> , and that death occurred at <b>1240 PM</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Thomas E. Curtin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 3, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <input checked="" type="checkbox"/> <b>THOMAS E. CURTIN</b>					22d. ADDRESS <b>4600 Connecticut Ave N.W. Wash D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

(M)

RECEIVED BY MAIL FOR DEPOSIT

1873

STATE OF NEW YORK

1873

IN SENATE,  
January 1, 1873.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN ANSWER TO A RESOLUTION  
PASSED BY THE SENATE,  
MAY 1, 1872.  
ALBANY:  
J. B. LEECH, PRINTER,  
1873.

ALBANY:  
J. B. LEECH, PRINTER,  
1873.

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MEDICAL CERTIFICATION  
1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is fully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14134

14103

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1424 University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Jacob (NMN) Hoffman</u>		4. DATE OF DEATH <u>Dec 1 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-95</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kaplan</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army W.W.I.</u>				16. SOCIAL SECURITY NO. <u>569-01-3151</u>				17. INFORMANT <u>Hospital Records.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ANGINA PECTORIS</u> (a), stating the underlying cause last. DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>DIABETES MELLITUS &amp; CHRONIC BRONCHITIS</u>																INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3-4 YRS</u> <u>5-6 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> to <u>12/1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>61</u> , and that death occurred <u>12/1</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Harold Stearns</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>HAROLD STEARNS, M.D.</u>				22d. ADDRESS <u>1352 UNIVERSITY BLVD</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-4-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE MD</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Shekley Funeral Home</u>				ADDRESS <u>4217-9200 N D.C.</u>				25a. REC'D BY REGISTRAR <u>DEC 5 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

(M)

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11111

MD

WATSON

MT CARMEL

11-11



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14135											
14104											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Georgia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 9 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlanta					
3. NAME OF DECEASED (Type or print) Dorothy Ann Holcombe						4. DATE OF DEATH December 23, 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 13, 1955		9. AGE (In years last birth day) 6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Georgia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Leonard Eugene Holcombe				14. MOTHER'S MAIDEN NAME Beverly Lee McKenzie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic Fibrosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 Year 6 Years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Atlanta, Georgia		(State)	
21. I certify that (I) (this hospital) attended the deceased from December 14, 19 61 to December 23, 19 61, that (I) (we) last saw the deceased alive on December 23, 19 61, and that death occurred at 12:08 PM from the causes and on the date stated above.											
22a. SIGNATURE William O. Jones M.D.						22b. DATE 12-23-61					
22c. PHYSICIAN'S NAME (Type) William O. Jones M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 12/23/61		23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City, town or county) Atlanta, Georgia			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. 2901 14th St., N.W. Washington, D.C.						25a. REC'D BY REGISTRAR DATE DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

14404

14133

THE U.S. AIR FORCE  
WASHINGTON, D.C.  
1950

REMOVED 12/1/50

William O. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MEDICAL CERTIFICATION

MONTGOMERY MARYLAND											
14136											
14105											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					
c. LENGTH OF STAY in 1b <b>2 hrs 25 min</b>						d. STREET ADDRESS <b>10701 McARTHUR BLVD.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILDRED E HOLT</b>						4. DATE OF DEATH Month Day Year <b>12 5 1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-11-09</b>		9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Husband</b>		Address <b>Same rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACEREBRAL hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (c) <b>DUE TO</b> (e), stating the underlying cause last, (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 5, 1961</b> to <b>Dec 5, 1961</b> (that I) (we) last saw the deceased alive on <b>Dec 5, 1961</b> and that death occurred at <b>2:30 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John J. Curry</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>						22d. ADDRESS <b>10670 Georgetown S.S., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

3854

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14137

## CERTIFICATE OF DEATH

Item 23b Film G304 12/29/61 mh

14106

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>1321 Shepard Street NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Almer Lee Hopkins</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 2, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>51</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Osborn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reticulum cell sarcoma, massive, retroperitoneum</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25, 1961</u> to <u>Dec. 15, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec. 15, 1961</u> , and that death occurred at <u>3:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Adam T. Thorp Jr.</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>December 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ADAM T. THORP JR. LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 20 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Crouches Funeral Home</u> ADDRESS <u>51 K Street, N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

14100

14137



X



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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> g. LENGTH OF STAY in 1b <i>D.O.M.</i> h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium "H" Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 22</i> d. STREET ADDRESS <i>404 E. Melbourne Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Hosea</i>			4. DATE OF DEATH Month Day Year <i>December 3 1961</i>			5. SEX <i>male</i>			6. COLOR OR RACE <i>white</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Month Day Year <i>May 12, 1891</i>			9. AGE (in years last birthday) 70 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Trade Unionist</i>			11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Hosea Hughes</i>						14. MOTHER'S MAIDEN NAME <i>Nellie Barton</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>						16. SOCIAL SECURITY NO. <i>577-03-3175</i>					
17. INFORMANT <i>wife</i>						Address <i>Same as above</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22. ACTUAL SIGNATURE <i>Frank J. Broschaw</i>						23. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
24. EXAMINER'S NAME (Type) <i>FRANK J. Broschaw</i>						25. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>12-3-61</i>					
26. ADDRESS (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			22b. DATE THEREOF <i>12/5/61</i>			22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			22d. LOCATION (City, town, or country) (State) <i>Prince Georges, Maryland</i>		
23. FUNERAL DIRECTOR <i>Raymond A. Ziska</i>						24. REC'D BY REGISTRAR <i>DEC 5 '61</i>					
25. ADDRESS <i>8434 Georgia Avenue</i>						26. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>					
27. WARNER E. PUMPHREY, INC. Silver Spring, Maryland											

2813

M

VR A15 (4)  
15M 9/60

## MEDICAL CERTIFICATION

621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14140

14109

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN lb <u>3 days</u>				d. STREET ADDRESS <u>8909 Ridge Place</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Kathryn L. Hutchison</u>				<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>26</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/10/86</u>	
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Iowa</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>George W. Young</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Weber</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Janice H. Ale (daughter) same as above</u>			
<b>17. INFORMANT</b> <u>Janice H. Ale (daughter)</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u></u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town) (County) (State)</b> <u></u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/27</u> , 19 <u>61</u> to <u>Dec 26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> , 19 <u>61</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Leo I Donovan MD</u>				<b>22b. DATE SIGNED</b> <u>12/26/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>LEO I DONOVAN MD</u>				<b>22d. ADDRESS</b> <u>8218 WISC. AVE</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/29/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cem. Rockville Pike MD</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u></u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cherry Chase Time Home Wash. DC</u>				<b>25. REC'D BY REGISTRAR</b> <u>DEC 29 '61</u>			
<b>25a. ADDRESS</b> <u>5101 Virginia Ave</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14110

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington b. COUNTY DC	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital Bethesda		d. STREET ADDRESS 908 Shepard St. N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Rose (N) JARSON		4. DATE OF DEATH Month Day Year December 9 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Feb 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Son) Maurice Jarson		Address Pensacola, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444x Encephalopathy DUE TO (b) arteriosclerosis and hypertension DUE TO (c) undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 21 Nov 1961 to 9 Dec 1961, that (I) (we) last saw the deceased alive on 9 Dec 1961, and that death occurred at 115PM, from the causes and on the date stated above. 22a. SIGNATURE Paul H. Linaweaver 22b. DATE SIGNED 9 Dec 1961 22c. PHYSICIAN'S NAME (Type) LCDR Paul G. Linaweaver MC USN 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 Dec 1961	
23c. NAME OF CEMETERY OR CREMATORY EZRAS ISRAEL		23d. LOCATION (City, town or county) (State) CAPITAL HEIGHTS, MARYLAND	
24. FURNERAL DIRECTOR'S SIGNATURE GOLDBERG		25a. REC'D BY REGISTRAR DATE DEC 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hase			



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Belmont (100)

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Director of Columbia

U. S. Naval Academy

900 Cherry St. N.Y.

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Director

Private

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				e. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>D.C.</i> b. COUNTY <i>D.C.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington 20, D.C.</i> d. STREET ADDRESS <i>800 Barnaby Street,</i>			
3. NAME OF DECEASED (Type or print) <i>Jeffries, Baby Boy</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>				9. AGE (In years last birthday) <i>12</i>			
6. COLOR OR RACE <i>White</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>no</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>no</i>				12. CITIZEN OF WHAT COUNTRY? <i>America</i>			
13. FATHER'S NAME <i>Larry Nicholas Ladrido</i>				14. MOTHER'S MAIDEN NAME <i>Marsha Elaine Jeffries</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>mother</i>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelectasis</i> 7(2.5) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <i>Prematurity</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>12-9</i> , 19 <i>61</i> , to <i>12-11</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>12-11</i> , 19 <i>61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.				22a. SIGNATURE <i>Robert A. Hare</i> M.D. 22c. PHYSICIAN'S NAME (Type) <i>Robert A. Hare, M. D. 7105 Riggs Rd., Lewisdale, Maryland</i>			
22b. DATE SIGNED <i>12-14-61</i>				22d. ADDRESS <i>Washington Sanitarium and Hospital, Takoma Park, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				23b. DATE THEREOF <i>12-12-61</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium and Hospital, Takoma Park, Md.</i>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M. D. Washington San. &amp; Hospital</i>				25a. REC'D BY REGISTRAR <i>DEC 18 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				25c. REGISTRAR'S SIGNATURE			

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D.O.

Washington, D.C.

100 Maryland Street,

Washington

James M. Smith

Smith

no

James M. Smith

no

no

no

Robert A. Smith, M.D., 100 Maryland Street, Washington, D.C.

12-12-51

Washington Sanitation and Hospital

Robert A. Smith, M.D., 100 Maryland Street, Washington, D.C.

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Item 18 Film 307 2-20-62 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14112											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Monty</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in lb <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u>				d. STREET ADDRESS <u>909 Maplewood Cuz</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>909 Maplewood Cuz</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>George Ellis Johnson</u>						4. DATE OF DEATH <u>Dec 31 1961</u>					
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-13</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>		11. BIRTHPLACE (State or foreign country) <u>Fredericksburg, S. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George E. Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Frances E. George</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-05-9948</u>		17. INFORMANT <u>Ella Furharty</u> Address <u>Stun 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREHEMORAL Congestive heart failure</u> 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty degeneration of liver - Edema of lungs</u> DUE TO (c) <u>Chronic alcoholism</u> INTERVAL BETWEEN ONSET AND DEATH <u>581.1</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead at foot of basement stairs, at home</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall down basement stairs at home</u>							
20c. TIME OF INJURY Month, Day, Year <u>Dec - 31 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Takoma Park</u>		20g. (County) <u>Monty</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>12-31-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>Jan 3/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>				22d. LOCATION (City, town, or country) <u>Colma Manor, Md.</u>	
23. FUNERAL DIRECTOR <u>Nalley's Funeral Home, Inc.</u>						ADDRESS <u>Mt. Rainier Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

11-22-1948

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

141144

## CERTIFICATE OF DEATH

141113

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>33 Rockville</u> d. STREET ADDRESS <u>12622 Shalomax St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Jones</u>		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>1</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec 1, 1961</u>		<b>9. AGE (In years last birthday)</b> yrs. <u>1</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>-</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Herbert Jones</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Virian Burgess</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>-</u> (If yes give year or dates of service) <u>-</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>				<b>17. INFORMANT</b> <u>Father -</u>				<u>Same as above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause or line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cardio-respiratory failure</u> DUE TO <u>Anencephaly</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>-</u> (c) <u>-</u>												INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>-</u> p.m. <u>-</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1, 1961</u> , <b>to</b> <u>Dec 1, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 1, 1961</u> , <b>and that death occurred at</b> <u>7:30 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Joseph O'Neil</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/1/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Joseph O'Neil</u>		<b>22d. ADDRESS</b> <u>809 Viers Mill Rd. Rockville Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u>				<b>23b. DATE THEREOF</b> <u>12-2-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u>				<b>23d. LOCATION (City, town or county)</b> <u>BETHESDA, MARYLAND</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Amelia C. Carter</u> <u>Suburban Hosp. Bethesda, Maryland</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 18 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Travis</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Montgomery  
Bostons  
Sturbridge

Male White  
Baby

Herbert Jones

Joseph O'Neil

Rockville  
Montgomery

1922-1923

Boy - Jones

Male, 1921

Marjorie  
Vivian Burgess

Father -

Dec 1, 1921

809 West Main St. Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14145

## CERTIFICATE OF DEATH

14114

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
c. LENGTH OF STAY IN 1b <u>1 day</u>			d. STREET ADDRESS <u>926 Massachusetts Ave. NE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Olivia</u> Middle <u>Mae</u> Last <u>Jones</u>			<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>12</u> Year <u>1961</u>		
<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>Caucasian</u>		
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>October 16, 1881</u>			<b>9. AGE</b> (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  - - - - -  </u>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>Thomas Cooper</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Cushcar</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>  - - - - -  </u>		
<b>17. INFORMANT</b> <u>HUSBAND: Calvin A. Jones, Same as #2</u>			<b>Address</b> <u>  - - - - -  </u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> (a), stating the underlying cause last. } DUE TO (c) <u>  - - - - -  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>  </u>		<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>	
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>Dec. 12, 1961</u> , to <u>Dec. 12, 1961</u> , that (X) (we) last saw the deceased alive on <u>Dec. 12, 1961</u> , and that death occurred at <u>11:40 PM</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Paul G. Linaweaver</u> M.D.					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>PAUL G. LINAWEAVER LCDR MC USN</u>					
<b>22b. DATE SIGNED</b> <u>December 13, 1961</u>					
<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-16-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Columbia Gardens</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Arlington, Va.</u>		<b>23e. (State)</b> <u>  </u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u>			<b>ADDRESS</b> <u>4th &amp; Massachusetts Ave, NE, WDC</u>		
<b>25a. REC'D BY REGISTRAR</b> <u>  </u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>		
<b>DATE</b> <u>DEC 15 '61</u>			<b>  </b>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14146					14115						
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 CHEVY CHASE						
c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL					d. STREET ADDRESS 1 19 GRAFTON STREET						
3. NAME OF DECEASED (Type or print) PAUL NMN Judson					4. DATE OF DEATH Month 12 Day 4 Year 19 61						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/6/61		9. AGE (In years last birthday) 8 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -					10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT JUDSON					14. MOTHER'S MAIDEN NAME MARCIA BARTLETT						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)					16. SOCIAL SECURITY NO. HOSPITAL RECORDS						
17. INFORMANT Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501X BRONCHOPNEUMONIA, BILATERAL. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TRACHEOBRONCHITIS, SEVERE. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MONGOLISM, CONGENITAL.											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
-			19								
21. I certify that (I) (this hospital) attended the deceased from JUNE 5, 1961 to DEC. 4, 1961, that (I) (we) last saw the deceased alive on DEC. 3, 1961, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE Charles S. Whitaker, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS CLARKSVILLE, MARYLAND					22b. DATE SIGNED 12/4/61	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 12-5-61		23c. NAME OF CEMETERY OR CREMATORY Landon Park			23d. LOCATION (City, town or county) Baltimore, Md			
24. FUNERAL DIRECTOR'S SIGNATURE J. H. Hargreaves					25a. REC'D BY REGISTRAR DATE DEC 6 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14147					14116					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN It <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Anhorige</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>55X-3</b> d. STREET ADDRESS <b>55X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Josephine Bedinger KIEREN</b>			4. DATE OF DEATH <b>December 31 1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>July 8, 1897</b>		9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months Days <b>64</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Daniel L. Bedinger</b>			14. MOTHER'S MAIDEN NAME <b>Eleanor G. Campbell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of endometrium</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>172X</b>			20g. (County) <b>172X</b>		20h. (State) <b>172X</b>		20i. (City or town) <b>172X</b>		20j. (County) <b>172X</b>	
20k. (State) <b>172X</b>			20l. (City or town) <b>172X</b>		20m. (County) <b>172X</b>		20n. (State) <b>172X</b>		20o. (City or town) <b>172X</b>	
20p. (County) <b>172X</b>			20q. (State) <b>172X</b>		20r. (City or town) <b>172X</b>		20s. (County) <b>172X</b>		20t. (State) <b>172X</b>	
20u. (City or town) <b>172X</b>			20v. (County) <b>172X</b>		20w. (State) <b>172X</b>		20x. (City or town) <b>172X</b>		20y. (County) <b>172X</b>	
20z. (State) <b>172X</b>			20aa. (City or town) <b>172X</b>		20ab. (County) <b>172X</b>		20ac. (State) <b>172X</b>		20ad. (City or town) <b>172X</b>	
20ae. (County) <b>172X</b>			20af. (State) <b>172X</b>		20ag. (City or town) <b>172X</b>		20ah. (County) <b>172X</b>		20ai. (State) <b>172X</b>	
20aj. (City or town) <b>172X</b>			20ak. (County) <b>172X</b>		20al. (State) <b>172X</b>		20am. (City or town) <b>172X</b>		20an. (County) <b>172X</b>	
20ao. (State) <b>172X</b>			20ap. (City or town) <b>172X</b>		20aq. (County) <b>172X</b>		20ar. (State) <b>172X</b>		20as. (City or town) <b>172X</b>	
20at. (County) <b>172X</b>			20au. (State) <b>172X</b>		20av. (City or town) <b>172X</b>		20aw. (County) <b>172X</b>		20ax. (State) <b>172X</b>	
20ay. (City or town) <b>172X</b>			20az. (County) <b>172X</b>		20ba. (State) <b>172X</b>		20bb. (City or town) <b>172X</b>		20bc. (County) <b>172X</b>	
20bd. (State) <b>172X</b>			20be. (City or town) <b>172X</b>		20bf. (County) <b>172X</b>		20bg. (State) <b>172X</b>		20bh. (City or town) <b>172X</b>	
20bi. (County) <b>172X</b>			20bj. (State) <b>172X</b>		20bk. (City or town) <b>172X</b>		20bl. (County) <b>172X</b>		20bm. (State) <b>172X</b>	
20bn. (City or town) <b>172X</b>			20bo. (County) <b>172X</b>		20bp. (State) <b>172X</b>		20bq. (City or town) <b>172X</b>		20br. (County) <b>172X</b>	
20bs. (State) <b>172X</b>			20bt. (City or town) <b>172X</b>		20bu. (County) <b>172X</b>		20bv. (State) <b>172X</b>		20bw. (City or town) <b>172X</b>	
20bx. (County) <b>172X</b>			20by. (State) <b>172X</b>		20bz. (City or town) <b>172X</b>		20ca. (County) <b>172X</b>		20cb. (State) <b>172X</b>	
20cc. (City or town) <b>172X</b>			20cd. (County) <b>172X</b>		20ce. (State) <b>172X</b>		20cf. (City or town) <b>172X</b>		20cg. (County) <b>172X</b>	
20ch. (State) <b>172X</b>			20ci. (City or town) <b>172X</b>		20cj. (County) <b>172X</b>		20ck. (State) <b>172X</b>		20cl. (City or town) <b>172X</b>	
20cm. (County) <b>172X</b>			20cn. (State) <b>172X</b>		20co. (City or town) <b>172X</b>		20cp. (County) <b>172X</b>		20cq. (State) <b>172X</b>	
20cr. (City or town) <b>172X</b>			20cs. (County) <b>172X</b>		20ct. (State) <b>172X</b>		20cu. (City or town) <b>172X</b>		20cv. (County) <b>172X</b>	
20cw. (State) <b>172X</b>			20cx. (City or town) <b>172X</b>		20cy. (County) <b>172X</b>		20cz. (State) <b>172X</b>		20da. (City or town) <b>172X</b>	
20db. (County) <b>172X</b>			20dc. (State) <b>172X</b>		20dd. (City or town) <b>172X</b>		20de. (County) <b>172X</b>		20df. (State) <b>172X</b>	
20dg. (City or town) <b>172X</b>			20dh. (County) <b>172X</b>		20di. (State) <b>172X</b>		20dj. (City or town) <b>172X</b>		20dk. (County) <b>172X</b>	
20dl. (State) <b>172X</b>			20dm. (City or town) <b>172X</b>		20dn. (County) <b>172X</b>		20do. (State) <b>172X</b>		20dp. (City or town) <b>172X</b>	
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Benjamin (1911)

U.S. Naval Hospital

Josephine

Benjamin

Alfred

December

July 8, 1937

Concession

Female

Homeville

Virginia

Benjamin J. Benjamin

Blanche G. Campbell

Hospital Records

No

XX

1 December 31

1 December 31

1 December 31

ROBERT H. WALKER JR MC USN

U.S. Naval Hospital Bethesda, MD

Clinton National

Clinton National

Robert H. Walker Jr, 1937 Wisconsin Ave.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14149  
CERTIFICATE OF DEATH

14118

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>1 mth</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Parroll Hall Sanatorium</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u> d. STREET ADDRESS <u>10039 Frederick Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNADETTE OLIVIA KINGSBURY</u>		4. DATE OF DEATH Month Day Year <u>Dec. 12. 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 16, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Thomas Kingsbury</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>J. Manning Kingsbury</u>		Address <u>(same as #2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 52 SX DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic pulmonary fibrosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1957</u> to <u>Dec. 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11, 1961</u> , and that death occurred at <u>10:30 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. E. Fitzgerald</u>		22b. DATE SIGNED <u>12/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. E. FITZGERALD</u>		22d. ADDRESS <u>3750-Reservoir Rd NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 15, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Barnesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Patton</u>		25a. REC'D BY REGISTRAR <u>DEC 15 '61</u>	
ADDRESS <u>254 Carroll St. NW Washington DC</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have", "I am", and "I will" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14150

CERTIFICATE OF DEATH

14119

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN lb <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 KEN SINGTON</b> d. STREET ADDRESS <b>2902 MC COMAS AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CATHERINE L KOUNS</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/95</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Dillon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee Stone</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>540.0</b>		17. INFORMANT <b>Daughter Mrs. Mary Botts</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>MASSIVE ATELECTASIS</b> <b>RESPIRATORY INSUFFICIENCY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>BLEEDING GASTRIC ULCER - SUBTOTAL GASTRECTOMY FOR,</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.?</b>	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>DEC 6, 1961</b> , to <b>DEC 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>DEC 14, 1961</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John P. Haberlin</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HABERLIN</b>				22d. ADDRESS <b>1015 SPRING ST SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kouns</b>	

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Burial 12/10/61 Mr. Oliver Cemetery Washington, D. C.

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14151

14120

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> <b>37 days</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Washington</b> <b>District Of Columbia</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3236 Prospect Street, N.W.</b> g. STREET ADDRESS h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary Carolyn Latimer</b>		<b>4. DATE OF DEATH</b> <b>December 7, 19 61</b>		<b>5. SEX</b> <b>Female</b>			
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 25, 1929</b>			
<b>9. AGE</b> (In years last birthday) <b>32 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>7</b> Days <b>19</b>		<b>IF UNDER 24 HRS.</b> Hours <b>1</b> Min. <b>61</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Legislative Assistant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Missouri</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Carl Ernest Ames</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Dorothy Banfield</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b>		<b>17. INFORMANT</b> <b>The Medical Records</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO Condillons, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Pulmonary Embolus</b> DUE TO (c) <b>Congenital or Rheumatic Heart Disease - Aortic Stenosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 min.</b> <b>5 min</b> <b>31 years</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> <b>(1)</b> (this hospital) attended the deceased from <b>October 31, 19 61</b> to <b>December 7, 19 61</b> that <b>(1)</b> (we) last saw the deceased alive on <b>December 7, 19 61</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Kenneth L. Melmon</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Kenneth L. Melmon, M.D.</b>		<b>22b. DATE SIGNED</b> <b>December 8, 1961</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Dec. 8, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Los Angeles, Calif.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W W Taltavull</b>		<b>ADDRESS</b> <b>3603 14th St NW</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 11 61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b>							



12151

12150



*W. M. ...*

Dec 8, 1961

Los Angeles, Calif.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

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## 14152

## 14121

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Campbell</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lynchburg</b>		d. STREET ADDRESS <b>Route #1, Lemon Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>KENNETH EUGENE LAYNE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 June 1943</b>		9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Center</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Layne</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Dodson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>227-54-5827</b>		17. INFORMANT <b>The Medical Record</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Urate Nephropathy</b> (c) <b>Acute Lymphocyte Leukemia</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>24 hrs.</b> <b>10 mos.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>November 27, 1961</b> to <b>December 12, 1961</b> , that <b>11</b> (we) last saw the deceased alive on <b>December 12, 1961</b> , and that death occurred at <b>3:10 a.m.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Edward S. Henderson</b> M.D.		22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>EDWARD S. HENDERSON, M.D.</b>		22d. DATE SIGNED <b>12/12/61</b>		22e. REC'D BY REGISTRAR <b>DEC 15 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>12/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lynchburg, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>																	

1912

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Robert A. Humphrey, Bethesda, Maryland

Social-Insurance Act of 1935, Spring Hill Cemetery, Lynchburg, Virginia

Edward S. Whitcomb, D.D.

3:40 P.M.

12-12-12



14153

## CERTIFICATE OF DEATH

Reg. Dist. No.

11122

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		c. LENGTH OF STAY IN 1b <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ropin Nursing Home</b>		d. STREET ADDRESS <b>715 Marshall Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOUIS</b> First <b>(NMI)</b> Middle <b>LEIBROCK</b> Last		4. DATE OF DEATH <b>December 15,</b> 1961 Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machenist</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>272-03-2602</b>	
17. INFORMANT <b>Mrs <del>Ann L.</del> Ann L. Welsh - Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA - (RENAL AZOTEMIA)</b> <b>593X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>CHRONIC RENAL FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 DAYS</b> <b>20 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>OLD FRACTURE RIGHT HIP - PNEUMONIA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEP 27, 1961</b> to <b>DEC 16, 1961</b> , that I last saw the deceased alive on <b>DECEMBER 15, 1961</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>310 W. Montgomery Ave, Rockville, Maryland</b> DATE SIGNED <b>DEC 15, 1961</b>			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>12/15/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>The West Part Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 18 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14154

Item 8 Film G303 12/21/61 iwk

14123

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wade Hamilton Leizear</b>				4. DATE OF DEATH Month Day Year <b>12 11 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/3/79 1880</b>	
9. AGE (In years last birthday) <b>81</b> Yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montg. Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Leizear</b>				14. MOTHER'S MAIDEN NAME <b>Annie Pagett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-14-6652</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY ARTERIOSCLEROSIS</b> (c) <b>10 yr</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>Dec</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 10</b> , 19 <b>61</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A.D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A.D. Bonifant</b>				22d. ADDRESS <b>Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town or county) (State) <b>Olney, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 14 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



General Atherosclerosis  
Heart Myocardial Infarction

71-11-682 Hospital Records

Samuel Baker

Anna Baker

White

White

White

White

White

White

Hamilton

Hamilton

Montgomery, General

Other

Other

Montgomery

Montgomery

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14124

14155

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN b <b>4 45days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> <b>Route 1</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna Magrel Lifka</b>		4. DATE OF DEATH <b>December 13, 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1895</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>home-making</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Czechoslovakia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>unknown USA</b>		13. FATHER'S NAME <b>Karl Magrel</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Woiafka</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomucinous Cyst</b> <b>175.0</b> DUE TO <b>Adenocarcinoma, Ovary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left. Metastatic.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 1961</b> to <b>12-13, 1961</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>12-13, 1961</b> , and that death occurred <b>6:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b> M.D.		22b. DATE SIGNED <b>12-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M.D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, RE (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 16 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven</b>	23d. LOCATION (City, town or county) (State) <b>Silver Spring Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>DEC 18 '61</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1933

1933

Montgomery

Montgomery

1933

1933

1933

1933

Montgomery General Hospital

Black

White

White

January 29, 1933

Female

1933

1933

Home-making

Elizabeth Wolcott

Karl Vogel

Hospital records

Unknown

WATKINS, WYOMING

WATKINS, WYOMING

1933

1933

1933

Paysonville, Wyo.



TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14156

14125

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda - 9200 Kiewit Ave</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>				d. STREET ADDRESS <u>825 New Hampshire Ave NW</u>			
3. NAME OF DECEASED (Type or print) First <u>HANNA</u> Middle <u>ANDERSON</u> Last <u>LINDSTROM</u>				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>SWEDEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREA ANDERSON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>HAROLD LINDSTROM (son)</u>		Address <u>825 New Hampshire Ave NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>CORONARY ARTERY DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>60</u> to <u>Dec.</u> 19 <u>61</u> , that (I) ( <input checked="" type="checkbox"/> ) lost saw the deceased alive on <u>12/30</u> 19 <u>61</u> , and that death occurred at <u>10:25</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Dyer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER, M.D.</u>				22d. ADDRESS <u>915 19th St. N.W. Wash, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMO. PARK</u>		23d. LOCATION (City, town, or county) (State) <u>MINNEAPOLIS, MINN.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 3072 M St NW Wash DC</u>				25a. REC'D BY REGISTRAR <u>JAN 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14157

## CERTIFICATE OF DEATH

1/2/62 iwk

14126

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>MONTGOMERY</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Caroline</i> First <i>Locke</i> Last			4. DATE OF DEATH <i>Dec. 25</i> 19 <i>61</i> Month Day Year		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1910</i>	9. AGE (In years last birthday) <i>51</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Keeper</i>			11. BIRTHPLACE (County & State, or foreign country) <i>South Dakota</i>		
10b. KIND OF BUSINESS OR INDUSTRY <i>private</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If available give war or date of service)	17. INFORMANT <i>Suburban Hosp. Records.</i> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute peritonitis</i> <i>570.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>leakage, anastomotic site</i> DUE TO (c) <i>Obstruction small intestine, Status postoperative</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>1 Day</i> <i>6 Days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral atelectasis with pulmonary edema</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>12/18</i> , 19 <i>61</i> , to <i>12/25</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>12/25</i> , 19 <i>61</i> , and that death occurred at <i>4:55 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Frederick Y. Donn</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/26/61</i>		
22c. PHYSICIAN'S NAME (Type) <i>Frederick Y. Donn</i>		22d. ADDRESS <i>1835 I St., N.W. Wash. DC.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)		
<i>Burial-transit</i>	<i>12-27-61</i>	<i>St. Peter &amp; Paul Cem.</i>	<i>Dimock, South Dakota.</i>		

24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Md.</i>	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>
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DEC 28 '61

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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Robert A. Humphrey, Helmsdale, N.Y.  
Burial-Grant: 12-17-01 S. Peter & Paul Chh. Helmsdale, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14158 Item 1 Film G304 1/4/62 iwk 14127											
1											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hosp. (died enroute to Hosp.) 5609 Johnson Avenue</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>45 Bethesda</b> d. STREET ADDRESS <b>5609 Johnson Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary H Logan</b>			4. DATE OF DEATH <b>December 28 19 61</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8/11/1878</b>			9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b>			IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Luke Allen Howland</b>			14. MOTHER'S MAIDEN NAME <b>(Unknown) Perkins</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mrs. James Davis-Daughter-same 2d</b>			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Generalized Arteriosclerosis</b> cause listed (c) <b>-----</b>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>5/11/61</b> to <b>12/31/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/28/61</b> , 19 <b>61</b> , and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>W. T. Joyce</b> M.D.		
22c. PHYSICIAN'S NAME (Type) <b>W. T. Joyce</b>			22d. ADDRESS <b>8106 Maple Ridge Rd., Bethesda, Md.</b>			22b. DATE SIGNED <b>1/28/62</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 1/2/62</b>			23b. DATE THEREOF <b>Howland Cemetery</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Quincy, Kentucky</b>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR <b>JAN 2 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			25c. DATE		

(M)

11152

11152

DOA

Between

and Johnnie Johnson

Hogan

WILLIAMS

Kenrick

(in name) Garrison

Mr. James Walter-Banister-James

Johnnie Johnson

James

Robert A. Pughner, Bethesda, Maryland  
Burial-Place 1/1/62 Howard Cemetery

Quincy, Kentucky



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14159

14128

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 Mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 Silver Spring</b>		d. STREET ADDRESS <b>1 9620 Bruce Drive</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wheaton Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Vernon</b> Last <b>Long</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1961</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/1880</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pt. Republic, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Franklin Hudlow</b>			14. MOTHER'S MAIDEN NAME <b>Lucy Michael</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Nursing Home Records- Wheaton, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma R. Breast-metastatic</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <b>18 Nov 1961</b> to <b>1 Dec 1961</b> that (I) (we) last saw the deceased alive on <b>27 Nov 1961</b> , and that death occurred at <b>12:45</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Ira N. Tublin</b>				22b. DATE SIGNED		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>Ira N. Tublin</b>				22d. ADDRESS <b>25 E. Wayne Ave. Silver Spring Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>				25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		

1122

(M)

Montgomery

Barfield

Montgomery

Wheaton

32 No.

Silver Spring

Wheaton Building House

5555 Bruce Drive

Knights

Verdon

Long

white

12/2/85

50

Houswife

11. Republic, Va.

U.S.A.

Franklin Swift

Lucy Michael

none

Working none record - Wheaton, Md.

Carolinavyshe

Carolinom R. Green-mastic

artificially heart disease

*John H. Tolin*

John H. Tolin

222 E. Wayne Ave.

Silver Spring  
Maryland

8/1/81

12/1/81

John H. Tolin

2501 Main St. N.W.

The S.H. Mines Co. Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14160

14129

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Lewisdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural- Lewisdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD # 1, Monrovia</u>		d. STREET ADDRESS <u>1 RFD # 1, Monrovia</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Tywana Renae Lyles</u>		<b>4. DATE OF DEATH</b> Last <u>Dec.</u> Month <u>1</u> Day <u>19</u> Year <u>61</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>March 24, 1961</u>
<b>9. AGE</b> (In years last birthday) <u>8</u> <b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>7</u> Hours <u> </u> Min. <u> </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u> </u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u> </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Frederick, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>George Lyles</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Dyson</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u> </u>	
<b>16. SOCIAL SECURITY NO.</b> <u> </u>		<b>17. INFORMANT</b> <u>George Lyles, Item 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial asthma</u> <u>501X</u> DUE TO (b) <u>Acute tracheobronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u> </u>		<b>20f. (City or town)</b> (County) (State) <u> </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/12</u> <b>19</b> <u>61</u> , <b>to</b> <u>12/1</u> <b>19</b> <u>61</u> , <b>that (I) (the) last saw the deceased alive on</b> <u>12/1</u> <b>19</b> <u>61</u> , <b>and that death occurred at</b> <u>10:15</u> <b>P.M.</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>James P. Kerr</u>		<b>22b. DATE SIGNED</b> <u>12/1/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>James P. Kerr</u>		<b>22d. ADDRESS</b> <u>Damascus, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/3/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Grove</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Purdum, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John L. Wolsmith</u>		<b>25a. REC'D BY REGISTRAR</b> <u> </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u> </u>		<b>DATE</b> <u>DEC 5 '61</u>	

206 9304-XV6

VR A15 (4)  
15M 9/60

M

12/3/51

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14161

## CERTIFICATE OF DEATH

Reg. Dist. No. 14130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>3825 Legation St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>C.</u> Last <u>Macatee</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28 - 1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Christ. Science Practitioner</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Mobile Bay, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robinson B. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Lina Doron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>YES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>11-22-</u> 19 <u>61</u> , to <u>12-22-</u> 19 <u>61</u> , that I last saw the deceased alive on <u>12-19</u> 19 <u>61</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.H. Ligon</u>		DATE SIGNED <u>12/22/61</u>	
PHYSICIAN'S NAME (Type) <u>C.H. Ligon</u>		ADDRESS (Street, city or town, state) <u>5045 Spring MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ainslie Cem</u>		22d. LOCATION (City, town, or county) <u>Bladensburg MD</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 N.W. Ave</u>	
24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Evans</u>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14162

Item 23c, Film G304 1/3/62 iwk

14131

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> d. STREET ADDRESS <b>8305 12th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Janet Mary MacLean</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> 8. DATE OF BIRTH <b>March 19, 1901</b> 9. AGE (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		4. DATE OF DEATH <b>December 28, 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Inverness, Scotland</b> 11. BIRTHPLACE (County & State, or foreign country) <b>England</b> 12. CITIZEN OF WHAT COUNTRY? <b>England</b>		13. FATHER'S NAME <b>Thomas Perry</b> 14. MOTHER'S MAIDEN NAME <b>Margaret Monroe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>- - - - -</b> 17. INFORMANT <b>DAUGH: Mrs. Margaret Asher, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>hours</b> <b>years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>Dec. 28, 1961</b> to <b>Dec. 28, 1961</b> that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 28, 1961</b> and that death occurred at <b>11:55 AM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Robert E. DeForest</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>ROBERT E. DEFOREST LT MC USN</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1-2-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Park Lawn Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>P.G. County, Rockville, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner Pumphrey</b> 25a. REC'D BY REGISTRAR <b>JAN 2 '62</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	



182

Montgomery

Bedford (Rural)

1 day

Silver Springs

800 12th Avenue

U. S. Naval Hospital

James

Mary

Wesland

December 28

01

Female

Canadian

1

March 19, 1911

60

Holmesville

Inverness, Scotland

England

Thomas Perry

Margaret Monroe

No

DAUGHT: Mrs. Margaret Labor, same as

XX

Dec. 28

01

Dec. 28

11:55 AM

Dec. 28

01

1 December 28, 1901

ROBERT E. DUNSTON IN NO USE U. S. Naval Hospital, Bedford, Maryland

1-2-02

Bureau

Residence Pennsylvania

Holmesville, Maryland

Margaret Perry, Funeral Home, 677 Geary Ave.,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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VR A15 (4)  
15M 9/59

14163

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> COUNTY <b>FAIRFAX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Perrin</b> Last <b>Mangan</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1877</b>
9. AGE (In years last birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Potomac Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph T. Mangan</b>		14. MOTHER'S MAIDEN NAME <b>Nora Perrin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>577-09-3690</b>	
17. INFORMANT <b>ROSA MANGAN KIRBY</b>		Address <b>McLean, Va. 4410 Chesterbrook Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Insanition</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>20+ yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1940</b> , to <b>12/11/61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12-17-61</b> , and that death occurred on <b>11-8</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. H. Aschenbach</b>		22b. DATE SIGNED <b>12/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. H. Aschenbach</b>		22d. ADDRESS <b>1841 Col Rd NW</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-14-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. ...</b>		25. REC'D BY REGISTRAR <b>DEC 13 '61</b>	
26. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>		27. DATE <b>DEC 13 '61</b>	

PATENT

WILLIAM C. BENTLEY

Patent Electric Co. Richmond, Va.

Northampton

677-00-3500

10-1-1901 at. Oliver J. Bentley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14164

14133

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village</u>				c. LENGTH OF STAY IN 1b <u>22 YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5021 Worthington Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARION CATHERINE MANN</u>				4. DATE OF DEATH <u>Dec 27, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 29, 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Melchior</u>				14. MOTHER'S MAIDEN NAME <u>Grace Steiner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>H.W. MANN</u> Address <u>Yorktown Village, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March</u> , 19 <u>59</u> to <u>Dec 27</u> , 19 <u>61</u> , that (I) <del>last</del> saw the deceased alive on <u>Dec 27</u> , 19 <u>61</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry N. Carlton</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>				22d. ADDRESS <u>940-25th St, N.W. WASH 7, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>				25a. REC'D BY REGISTRAR <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14165		14134	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda 45</u>	
c. LENGTH OF STAY in 1b <u>5 hrs</u>		d. STREET ADDRESS <u>10003 Clue Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen L Manno</u>	First Middle Last	4. DATE OF DEATH <u>Dec 16 1961</u>	Month Day Year
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/28</u>
9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u></u> Min. <u></u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chester PA.</u>	
13. FATHER'S NAME <u>Fury Oleksey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Korean War</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Husband</u>		Address <u>Joseph R. Manno Same 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>THROMBOCYTOPENIA</u> (a), stating the underlying cause last. (c) <u>ACUTE MYELOCYTIC LEUKEMIA</u> 2 MOS. 2 MOS.			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>DEC. 3, 1961</u> to <u>DEC. 16, 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>DEC. 16, 1961</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Tuohy</u> M.D.		22b. DATE SIGNED <u>12-16-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. TUOHY, M.D.</u>		22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 12/19/61 Emaculate Cem.</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Chester, Pennsylvania</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 21 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

Burial-Transit 12/19 of Emanuel's son.  
Robert A. Ramsey, Bethesda, Maryland

Copy of  
H. T. Ramsey

Transit-Transit  
Bethesda, Maryland

NAME

Acute Myocardial Infarction

Transit-Transit

DELIVERED TO THE

Joseph R. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14166 CERTIFICATE OF DEATH 14136											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>				d. STREET ADDRESS <u>9411 Colesville Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>P.</u> Last <u>Mason</u>						4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Plumley</u>				14. MOTHER'S MAIDEN NAME <u>Susan RICHMOND</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. RICHARD F. MASON SILVER SPRING, MARYLAND</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> <u>uremia</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Dec 9</u> , 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Dec 8</u> , 19 <u>61</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Seruth T. Kimble</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9 Dec 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>SERUTH T. KIMBLE</u>						22d. ADDRESS <u>927 Pershing Drive Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>MONTGOMERY MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>						25a. REC'D BY REGISTRAR <u>DEC 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14167

## CERTIFICATE OF DEATH

14137

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>six days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1657-2 d. STREET ADDRESS <u>8500 New Hampshire Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Marjorie</u> Middle <u>Mathis</u> Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>11-20-18</u> 43 yrs. 9. AGE (In years last birthday) <u>43</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Secretary</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. E. Richardson</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Mathis</u> 14. MOTHER'S MAIDEN NAME <u>Emma Sue Maroney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>426-03-7472</u> 17. INFORMANT <u>Hospital Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (the <u>hospital</u> ) attended the deceased from <u>12 Dec</u> , 19 <u>61</u> , to <u>18 Dec</u> , 19 <u>61</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>17 Dec</u> , 19 <u>61</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H.B. Queen</u> M.D. 22b. DATE SIGNED <u>18 Dec 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>M.B. QUEEN M.D.</u> 22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/21/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Harris Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Carthage, Mississippi</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u> 25a. REC'D BY REGISTRAR <u>DEC 20 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14169  
CERTIFICATE OF DEATH  
14139

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> <b>XXXXXXXXXXXX</b> b. COUNTY <b>Washington</b> <b>47X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY in 1b <b>2 days</b>		d. STREET ADDRESS <b>4000 Massachusetts Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daniel J. McGill</b>		4. DATE OF DEATH <b>Dec. 28, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-98</b>
9. AGE (In years birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Edward McGill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Linskey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>577-10-5058</b>	
17. INFORMANT <b>Annie P. McGill, wife</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>2 yrs known</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> , 19 <b>61</b> to <b>12-28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> <b>8:00 AM</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard H. Pollen</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. POLLEN, M.D.</b>		22d. ADDRESS <b>10511 SUMMIT AVE KENSINGTON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-61</b>	
23c. NAME OF CEMETERY <b>Mount Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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U.S. Govt.

577-10-5038

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Mount Olive

12-30-51

Burial

Wash.

Francis J. Collins, 3031-1st St. N.W. D.C.

# CERTIFICATE OF DEATH

1414C

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>74 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Point Marion</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75x.3</b> d. STREET ADDRESS <b>201 Boulevard Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Everett Laing McGill</b> First Middle Last		4. DATE OF DEATH <b>December 5, 1961</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 May 1911</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph N. McGill</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Laing</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>204-10-9999</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Carcinoma of the lung with cerebral, hepatic and probable cardiac metastases.</b> DUE TO (c) <b>1 year</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 22, 1961</b> to <b>Dec. 5, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 5, 1961</b> , and that death occurred at <b>11:55 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>John C. Marsh</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John C. Marsh, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SMITHFIELD, PENNA.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>		25c. DATE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ath. Page 4 may be retained by the hospital or attending physician.  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

The Clinical Center, Bethesda, Md.  
The following information was obtained from the records of the Clinical Center, Bethesda, Md.

Verdict  
The following information was obtained from the records of the Clinical Center, Bethesda, Md.

U.S.A.  
The following information was obtained from the records of the Clinical Center, Bethesda, Md.

Examination of the lungs with coronal, sagittal and frontal sections.

The following information was obtained from the records of the Clinical Center, Bethesda, Md.

The following information was obtained from the records of the Clinical Center, Bethesda, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14171

14141

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>				c. LENGTH OF STAY IN 1b <b>0 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>715 Sprindale Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Richard Gordon Messer</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>December 29 1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 November 1903</b>		9. AGE (In years last birthday) <b>58 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Coast Guard Retired Buyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>			
13. FATHER'S NAME <b>George Messer</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Huff</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 1920-1945</b>				16. SOCIAL SECURITY NO. 				17. INFORMANT <b>Mrs. Mary E. MESSER, 715 Sprindale Ave., Annapolis, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Aortic Aneurysm</b> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
<b>21. I certify that XX (this hospital) attended the deceased from 29 December 1961, to 29 December 1961 that XX (we) last saw the deceased alive on 29 December 1961, and that death occurred 805PM, from the causes and on the date stated above.</b>											
22a. SIGNATURE <b>A. T. Thorp Jr.</b>				M.D. 				22b. DATE SIGNED <b>XX Dec. 30, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. T. THORP JR. LT MC USN</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/2/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>				23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR AND SONS</b>				ADDRESS <b>ANNAPOLIS, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14172

14142

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>606 Edmonston Dr.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Lester Messick</b>		4. DATE OF DEATH <b>December 4, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Messick</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Biller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-09-2357</b>	
17. INFORMANT <b>wife, Cordelia Messick-Same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rupture, left ventricle</b> (a), stating the underlying cause last. (c) <b>Myocardial infarct</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>-</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/11/1961</b> to <b>12/30/1961</b> , that (I) (we) last saw the deceased alive on <b>12/4/1961</b> , and that death occurred at <b>12/5/61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen N. Jones M.D.</b>		22b. DATE SIGNED <b>12/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones, M.D.</b>		22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/7/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetary</b>	23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 7, '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

Cardiac Thrombosis  
Rupture, left ventricle  
Hypertensive infarct

Robert A. Humphrey, Bethesda, Maryland, M.D.  
12/7/61 Parkland Cemetery, Rockville, Maryland  
Stephen M. Jones, M.D. 409 Vista Hill Rd. Rockville, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14173

## CERTIFICATE OF DEATH

14143

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>48 Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>4716 Bradley Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sylvester</b> Middle <b>Mettenburg</b> Last <b>Mettenburg</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/98</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Mettenburg</b>				14. MOTHER'S MAIDEN NAME <b>Anna Hellweg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Joseph A. Cantrel</b> (Executor)		Address <b>808 17th St. NW. Washington 6, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Atherosclerosis</b> (c) <b>420.1</b> DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/5/61</b> to <b>Dec 2</b> , 19 <b>61</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>12/1</b> , 19 <b>61</b> , and that death occurred at <b>6:30</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>W. T. Joyce</b>				22b. ADDRESS <b>8106 Maple Ridge Road, Bethesda, Md</b>		22c. DATE SIGNED <b>12/2/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans-12/5/61</b>				23b. DATE THEREOF <b>12/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Church Cem.</b>	
23d. LOCATION (City, town or county) (State) <b>Houghton, Iowa</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

65125





Montgomery

May

2 days

Montgomery General Hospital

Grace

Elizabeth

Myers

12

03

11/3/1890-1901-12

Law

Elizabeth

Elizabeth Wilson

William Henry Wilson

Hospital location

Unknown

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William Henry Wilson  
Grace  
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John S. Martin

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Elizabeth Wilson  
William Henry Wilson  
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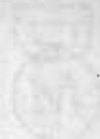
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MARYLAND STATE RESIDENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Buck Lodge</b>				c. LENGTH OF STAY IN Jb <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simpson Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Alby</b> Last <b>Miles</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1877</b>		9. AGE (In years lost birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Miles</b>				14. MOTHER'S MAIDEN NAME <b>Ella Beal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Ella M. Bosley Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4 4 3 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic-Hypertensive Cardiovascular Disease</b> 10 year							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>2 year</b> <b>10 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>29 July 1961</b> to <b>31 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>31 Dec 1961</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Gordon M. Smith</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2 Jan 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith, M.D.</b>				22d. ADDRESS <b>Barnesville Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>		23d. LOCATION (City, town, or county) (State) <b>Cedar Grove, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



CERTIFICATE OF DEATH

1917

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

CHIEF CLERK

TO THE CAPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO THE GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14175

14145

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>		d. STREET ADDRESS <b>4404 Ridge Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah Hays M. Miley</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1869</b>
9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>92</b> Days <b>15</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Months <b>92</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>alfred mordecai</b>		14. MOTHER'S MAIDEN NAME <b>sallie mayradier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. N. M. Asbburner-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Anoxia</b> (c) <b>Bronchopneumonia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1958</b> to <b>Dec 15, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Dec 13, 1961</b> , and that death occurred at <b>7:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William Henry Killax</b>		22b. DATE SIGNED <b>12/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Henry Killax</b>		22d. ADDRESS <b>8218 Wisconsin Av Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/19/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

CERTIFICATE OF DEATH

1912

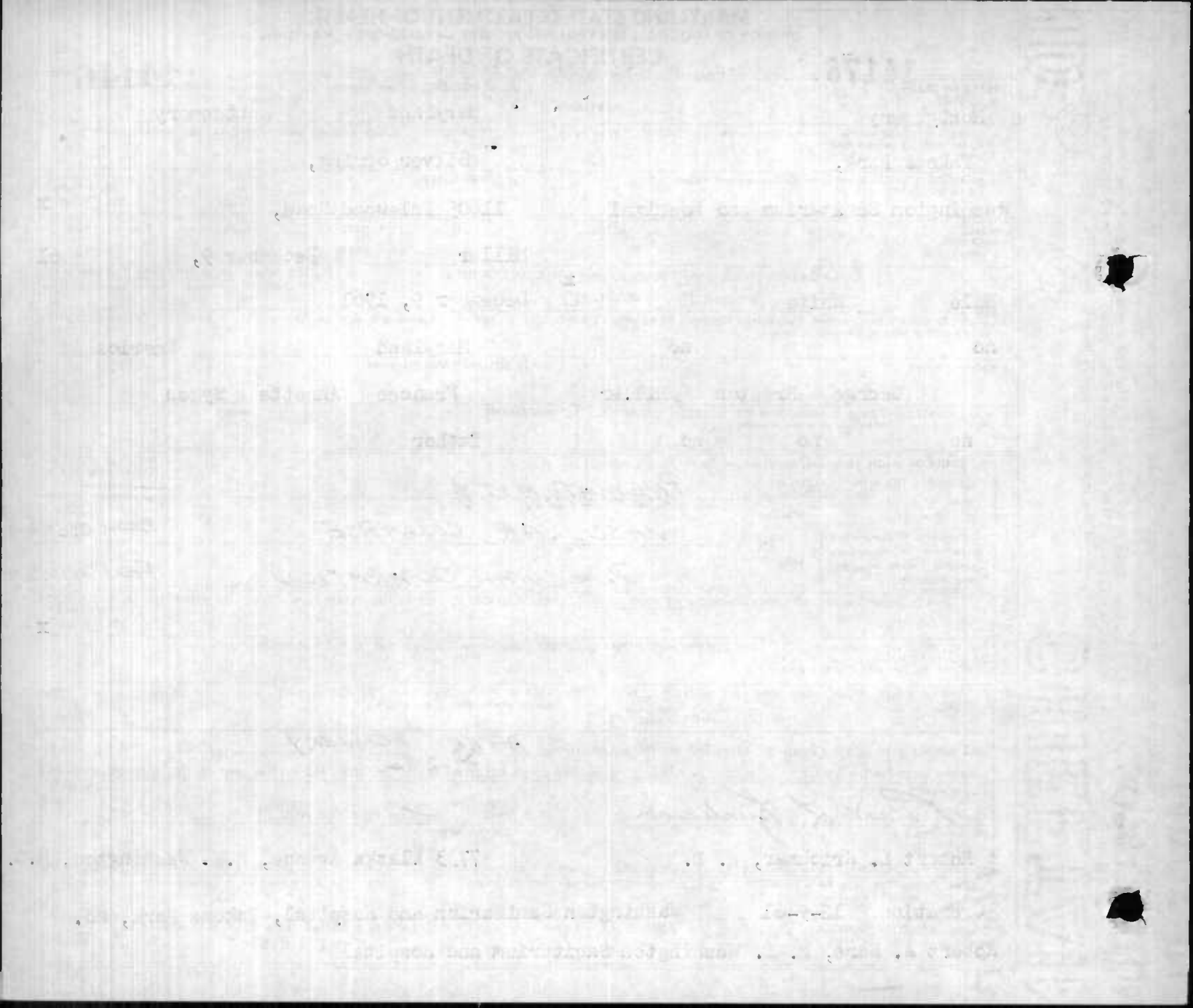


DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Silver Spring,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>11805 Idlewood Road,</b>	
3. NAME OF DECEASED (Type or print) <b>Miller</b>		4. DATE OF DEATH <b>December 9, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1961</b>
9. AGE (In years lost birthday) <b>761.5</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>George Preston Miller</b>		14. MOTHER'S MAIDEN NAME <b>Frances Annette Sykes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO <b>VASCULAR COLLAPSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PHACENTAL SEPARATION</b> DUE TO (c) <b>PHACENTAL SEPARATION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>FEW HOURS</b> <b>FEW HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AFTER BIRTH</b> 19____, that (I) (we) last saw the deceased alive on 19____, and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert L. Krichmar</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Krichmar, M. D.</b>		22d. ADDRESS <b>7733 Alaska Avenue, N.W. Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-9-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Washington Sanitarium and Hospital</b>		25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hare</b>			

2075-254150





TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 14117

14177

1. PLACE OF DEATH a. COUNTY <b>Mpntgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b <b>43</b> <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4214 Brookfield Drive</b>				d. STREET ADDRESS <b>4214 Brookfield Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>P</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/91</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>28</b> Hours <b></b> Min. <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Schools, fet Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Deleware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank M. Stoever</b>				14. MOTHER'S MAIDEN NAME <b>(Unknown) Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>			
17. INFORMANT <b>J. W. Belt-Son in law-same 2d</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM</b> <b>154X</b> DUE TO <b>WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>APRIL 1957</b> to <b>DECEMBER 13 1961</b> , that I last saw the deceased alive on <b>DECEMBER 13 1961</b> , and that death occurred at <b>230 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <b>Robert L. Krichmar</b>				M.D. <b>7733 ALASKA AVENUE N.W. DEC. 13 1961</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR</b>				<b>WASHINGTON 12 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Haines</b>	

MEDICAL CERTIFICATION



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

1  
14178  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville d. STREET ADDRESS Thompson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES LUTHER MINNICK		4. DATE OF DEATH December 17 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1880	
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - selfemployed		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James D. Minnick		14. MOTHER'S MAIDEN NAME KXMA Chewing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-38-7758		17. INFORMANT Mr. Walter Minnick Address Thompson Road Spencerville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Coronary occlusion Interval between onset and death Found dead in bed		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12-18-61		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/61		22c. NAME OF CEMETERY OR CREMATORY New Hope Baptist Cemetery	
22d. LOCATION (City, town, or county) (State) Orange County, Virginia		23. FUNERAL DIRECTOR A. Ziska Wardner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland			
24a. REC'D BY REGISTRAR DEC 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14179

14149

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b <u>21 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>18712 COLESVILLE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>EVELYN HOLLAND MONROE</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>8</u> Year <u>1961</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-23-1870</u>
<b>9. AGE</b> (In years last birthday) <u>91</u> yrs.		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>NAMES HOLLAND</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Flenner</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Frank J. Rapee</u> Address <u>8712 Colesville Road Silver Spring, Maryland</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis -</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis -</u> DUE TO (c) <u>4 1/2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 days</u> INTERVAL BETWEEN ONSET AND DEATH			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 3</u> , 19 <u>61</u> , to <u>Dec 8</u> , 19 <u>61</u> , that (I) <u>had</u> last saw the deceased alive on <u>Dec 7</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Neil P. Campbell</u> M.D.		<b>22b. DATE, SIGNED</b> <u>12/8/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Neil P. Campbell II</u>		<b>22d. ADDRESS</b> <u>Kenesaw Apt</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>12/11/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GLENWOOD CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>WASHINGTON D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>		<b>25c. ADDRESS</b> <u>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</u>	

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WILLIAM L. THOMPSON, INC.  
SILVER SPRING, MARYLAND  
TELEPHONE 2-1117  
11179

WASHINGTON, D.C.

Mr. J. P. Campbell  
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Personnel

Box 11179

General Thompson  
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14180

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14150

141  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 X Chevy Chase</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>4411 Walsh St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4411 Walsh Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Matthias Paul Monson</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-28</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Matthias Monson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Peterson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW 2</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Patricia Monson (wife)</u>				Address <u>Stuen 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hanging</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Found hanging in garage at home</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bluscham</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-31-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Bluscham</u>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 3 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

11:00

(M)

Robert A. Humphrey, Bethesda, Maryland

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14181  
MONTGOMERY  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
14151

1. PLACE OF DEATH COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 19</b> d. STREET ADDRESS <b>8819 Piney Br. Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>Isaac Roland Moore</b>		4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>1961</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-31-98</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter.</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Isaac Moore</b>						14. MOTHER'S MAIDEN NAME <b>SUSAN Miles</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1-Army 578 14 5616</b>				17. INFORMANT <b>James E. Moore - 138 E ST S E Dc</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>sudden</b> (c) DUE TO <b>sudden</b> (e), stating the underlying cause last.														INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>History of previous coronary disease</b>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>12-4-61</b>																	
ACTUAL SIGNATURE <b>Frank J. Brosch</b>				DATE SIGNED <b>12-4-61</b>				EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 7, 1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Montgomery Co., Maryland</b>					
23. FUNERAL DIRECTOR <b>Raymond A. Ziska</b>				ADDRESS <b>Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 6 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>					
WALTER E. PUMPHREY, INC. 8434 Georgia Ave.																	

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
14182																	
14152																	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN lb <u>9 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6101 DUNLEER COURT</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE <u>OHIO</u> b. COUNTY <u>CUYAHOGA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEREA</u> d. STREET ADDRESS <u>201 S. ROCKY RIVER DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>EDNA</u> <u>STEWART</u> <u>MORGAN</u>						4. DATE OF DEATH <u>DECEMBER 5</u> 19 <u>61</u>											
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASOID</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 5, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>PCLAND, OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>DAVID HAMMOND STEWART</u>						14. MOTHER'S MAIDEN NAME <u>SARAH FRANCES GIESSE</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>29320-3258</u>						17. INFORMANT <u>MRS. HOMER THRALL</u> Address <u>BETHESDA, MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA; PULMONARY EDEMA</u> <u>4-20</u> DUE TO <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (b) <u>MYOCARDIAL INFARCTION</u> (a), stating the underlying cause last. (c) <u>15 WEEKS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 27, 1961</u> to <u>DEC 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>DEC 4, 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Joseph D. Connor</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>DEC 5, 1961</u>								
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR</u>						22d. ADDRESS <u>9420 OLD GEORGETOWN RD BETHESDA</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 12/6/61</u>			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY <u>Lake Park Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>South Youngstown, Ohio</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>DEC 7 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>								

1932

1932

1932

1932

Robert A. Humphrey, Bethesda, Maryland

Robert A. Humphrey, Bethesda, Maryland



14183

## CERTIFICATE OF DEATH

Reg. Dist. No. 4153

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOYDS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>Box 268 Route #1</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>MORTON</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1961</u>
9. AGE (In years lost birthday) yrs. <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BOBBY GENE MORTON</u>	
14. MOTHER'S MAIDEN NAME <u>AGNES LILLIAN BREEDEN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS, INTRACRANIAL HEMORRHAGE</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 hr 57 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC. 6, 1961</u> , to <u>DEC 6, 1961</u> , that I last saw the deceased alive on <u>DEC 6, 1961</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Anders</u> M.D.		ADDRESS (Street, city or town, state) <u>4700 Bradley Blvd Chevy Chase, Md</u> DATE SIGNED <u>12-6-61</u>	
PHYSICIAN'S NAME (Type) <u>THEODORE H. ANDERS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>12-7-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>BETHESDA, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia C. Carter, Admin. Suburban Hosp Bethesda, Md.</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 20 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

189

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF RECEPTIONIST	
25. SIGNATURE OF CHIEF CLERK		26. SIGNATURE OF DEPUTY CHIEF CLERK		27. SIGNATURE OF RECORDS CLERK	
28. SIGNATURE OF FILE CLERK		29. SIGNATURE OF INDEX CLERK		30. SIGNATURE OF DISTRIBUTION CLERK	
31. SIGNATURE OF MAIL CLERK		32. SIGNATURE OF TELETYPE CLERK		33. SIGNATURE OF TELEPHONE CLERK	
34. SIGNATURE OF TELEGRAPH CLERK		35. SIGNATURE OF TELEVISION CLERK		36. SIGNATURE OF RADIO CLERK	
37. SIGNATURE OF RECORDS CLERK		38. SIGNATURE OF INDEX CLERK		39. SIGNATURE OF DISTRIBUTION CLERK	
40. SIGNATURE OF MAIL CLERK		41. SIGNATURE OF TELETYPE CLERK		42. SIGNATURE OF TELEPHONE CLERK	
43. SIGNATURE OF TELEGRAPH CLERK		44. SIGNATURE OF TELEVISION CLERK		45. SIGNATURE OF RADIO CLERK	
46. SIGNATURE OF RECORDS CLERK		47. SIGNATURE OF INDEX CLERK		48. SIGNATURE OF DISTRIBUTION CLERK	
49. SIGNATURE OF MAIL CLERK		50. SIGNATURE OF TELETYPE CLERK		51. SIGNATURE OF TELEPHONE CLERK	
52. SIGNATURE OF TELEGRAPH CLERK		53. SIGNATURE OF TELEVISION CLERK		54. SIGNATURE OF RADIO CLERK	
55. SIGNATURE OF RECORDS CLERK		56. SIGNATURE OF INDEX CLERK		57. SIGNATURE OF DISTRIBUTION CLERK	
58. SIGNATURE OF MAIL CLERK		59. SIGNATURE OF TELETYPE CLERK		60. SIGNATURE OF TELEPHONE CLERK	
61. SIGNATURE OF TELEGRAPH CLERK		62. SIGNATURE OF TELEVISION CLERK		63. SIGNATURE OF RADIO CLERK	
64. SIGNATURE OF RECORDS CLERK		65. SIGNATURE OF INDEX CLERK		66. SIGNATURE OF DISTRIBUTION CLERK	
67. SIGNATURE OF MAIL CLERK		68. SIGNATURE OF TELETYPE CLERK		69. SIGNATURE OF TELEPHONE CLERK	
70. SIGNATURE OF TELEGRAPH CLERK		71. SIGNATURE OF TELEVISION CLERK		72. SIGNATURE OF RADIO CLERK	
73. SIGNATURE OF RECORDS CLERK		74. SIGNATURE OF INDEX CLERK		75. SIGNATURE OF DISTRIBUTION CLERK	
76. SIGNATURE OF MAIL CLERK		77. SIGNATURE OF TELETYPE CLERK		78. SIGNATURE OF TELEPHONE CLERK	
79. SIGNATURE OF TELEGRAPH CLERK		80. SIGNATURE OF TELEVISION CLERK		81. SIGNATURE OF RADIO CLERK	
82. SIGNATURE OF RECORDS CLERK		83. SIGNATURE OF INDEX CLERK		84. SIGNATURE OF DISTRIBUTION CLERK	
85. SIGNATURE OF MAIL CLERK		86. SIGNATURE OF TELETYPE CLERK		87. SIGNATURE OF TELEPHONE CLERK	
88. SIGNATURE OF TELEGRAPH CLERK		89. SIGNATURE OF TELEVISION CLERK		90. SIGNATURE OF RADIO CLERK	
91. SIGNATURE OF RECORDS CLERK		92. SIGNATURE OF INDEX CLERK		93. SIGNATURE OF DISTRIBUTION CLERK	
94. SIGNATURE OF MAIL CLERK		95. SIGNATURE OF TELETYPE CLERK		96. SIGNATURE OF TELEPHONE CLERK	
97. SIGNATURE OF TELEGRAPH CLERK		98. SIGNATURE OF TELEVISION CLERK		99. SIGNATURE OF RADIO CLERK	
100. SIGNATURE OF RECORDS CLERK		101. SIGNATURE OF INDEX CLERK		102. SIGNATURE OF DISTRIBUTION CLERK	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14154

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY COUNTY</b> <span style="float: right;"><b>MARYLAND</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (KENWOOD, MD.)</b>				c. LENGTH OF STAY IN 1b <b>YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6416 SHADOW ROAD, KENWOOD, MARYLAND</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>LILLIAN L. MOSES</b>				<b>4. DATE OF DEATH</b> <b>Dec. 31 1961</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JAN. 25, 1884</b>	
<b>9. AGE</b> (In years last birthday) <b>77 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>6</b>		<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WASHINGTON, DIST. OF COL.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>		<b>13. FATHER'S NAME</b> <b>JAMES T. HOWENSTEIN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY WADE SULLIVAN</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> (Daughter) <b>MRS. PATRICIA RICHARDS</b>		Address <b>ARLINGTON, VA. 2785 FT. SCOTT DRIVE</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral arteriosclerosis</b> (c) <b>6 mo.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive - Cardiovascular disease</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from July 27, 1961, to Dec. 30, 1961, that (I) (we) last saw the deceased alive on Dec 30, 1961, and that death occurred at 1200 M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Malcolm D. Harrison</i> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Dec. 31, 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>MALCOLM D. HARRISON</b>				<b>22d. ADDRESS</b> <b>4535 YUMA ST NW - WASH. D.C.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>CREMATION</b>		<b>23b. DATE THEREOF</b> <b>1/3/1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FORT LINCOLN CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>PRINCE GEORGES, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Martin W. Hyong Co.</i>				<b>25a. REC'D BY REGISTRAR</b> <b>JAN 3 1962</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hays</i>	

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marlander Rest Home</b>		d. STREET ADDRESS <b>4620 Butterworth St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Mullikin</b> Last <b>Mullikin</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29, 1864</b>
9. AGE (In years last birthday) <b>97</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Burgess</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Annie Wood, 4620 Butterworth St. N.W.</b>		Address <b>Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct-10, 1959</b> to <b>Dec-6, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Dec-4, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kern</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-8-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawrence</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>	
ADDRESS <b>1756-12 Ave, NW</b>		25b. REGISTRAR'S SIGNATURE <b>Thos E. Kline</b>	

(M)

(1)

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Washington

Washington

Washington

Washington

John

William

by

2-22, 1884

James

at home

Washington, D. C.

Elizabeth Cannon

James

Annals of the American Republics, 1880-1881, Vol. 1, No. 1, p. 1.

James

James

James



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14156

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				d. STREET ADDRESS <b>1119 CLAGETT DR.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BELVA M MULLINS</b>				4. DATE OF DEATH Month Day Year <b>DEC. 7 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/14</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>LEVI BOGGS</b>			
14. MOTHER'S MAIDEN NAME <b>GOLDIE BERRY</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 20 YEARS</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>CORONARY THROMBOSIS - DIABETES MELLITUS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>10 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 1961</b> to <b>DECEMBER 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 7, 1961</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Gordon Rosenberg</b>				22b. DATE SIGNED <b>December 7, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>GORDON ROSENBERGER</b>	
22d. ADDRESS <b>310 W. MONTG. AVE. ROCKVILLE, MARYLAND</b>				22e. ADDRESS <b>310 W. MONTG. AVE. ROCKVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/10/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meade</b>		23d. LOCATION (City, town or county) (State) <b>Pound, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gordon Rosenberg</b>				24b. ADDRESS <b>1331 E. MONTG. AVE. ROCKVILLE, MD.</b>		25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

LEVI BOERS  
Gordie Berry  
Virginia  
None

General  
Mills  
Mills  
Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14187

14157

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKMONT</u> c. LENGTH OF STAY IN 1b <u>5 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4103 Maryland Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKMONT</u> d. STREET ADDRESS <u>4103 Maryland Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Josephine Ellen Mutchler</u>		<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>20</u> Year <u>1961</u>					
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 8, 1875</u>	<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>William E. Burroughs</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Alice Frizzell</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Ida Johnson, Sister, Same as #2</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12 hrs</u>  <u>year</u>  <u>year</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July</u> <u>1958</u> <b>to</b> <u>20 Dec</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>20 Dec</u> <u>1961</u> , <b>and that death occurred at</b> <u>8 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Andrew Tesitore</u> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12-20-61</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ANDREW TESITORE</u>			<b>22d. ADDRESS</b> <u>114 Courthouse Rd SW Vienna Va</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>Dec. 23, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l.</u>			
		<b>23d. LOCATION</b> (City, town or county) (State) <u>Ft. Myer, Va.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co.</u> ADDRESS <u>3072-M St N.W. Wash, D.C.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>DEC 27 '61</u> DATE		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Christina S. Haines</u>		

MEDICAL CERTIFICATION

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Washington to Mrs. M. A. ...

Items 13 & 14 Film G302 12/11/61 iwl

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15M 9/60

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2352

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13  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
14189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
14159													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4515 Gridley Rd.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>mntg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>35 Wheaton</u> d. STREET ADDRESS <u>4515 Gridley Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>James Ketchum Nehmeus</u> First Middle Last 4. DATE OF DEATH <u>Dec. 18</u> Month Day Year <u>1961</u>						5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>1-15-1890</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u> 11. BIRTHPLACE (State or foreign country) <u>N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>John Nehmeus</u> 14. MOTHER'S M maiden NAME <u>Elinor Raymond</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>-----</u> 17. INFORMANT <u>Edith Gilbert (daughter)</u> Address <u>Slm 2</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-18-61</u> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>12/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cypress Hills</u>				22d. LOCATION (City, town, or country) (State) <u>Brooklyn New York</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> Silver Spring, Maryland						24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Walter S. Kraus</u>					

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*[Faint, mostly illegible handwriting on lined paper, possibly a ledger or notebook page. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14190

14160

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>27 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Newkirk</b> Last <b>Nelson</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/26/09</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13. FATHER'S NAME <b>Francis M. Newkirk</b>				14. MOTHER'S MAIDEN NAME <b>Verda Hughes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>M. Cary Nelson, husband</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with widespread metastases</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>170X</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Coronary heart failure</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-10-</b> 19 <b>61</b> , to <b>12-7-</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-7-</b> 19 <b>61</b> , and that death occurred at <b>338</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen W. Dejter</b>				22b. DATE SIGNED <b>12/7/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. S. Wm. Dejter</b>				22d. ADDRESS <b>6719 Wilson Lane, Beth. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14161

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY in 1b <u>12 yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11801 Judson Rd</u>				d. STREET ADDRESS <u>1 11801 Judson Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Ollie Ethel Newcomb</u>				4. DATE OF DEATH <u>Dec 6 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-1893</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
13. FATHER'S NAME <u>Wm G. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret O'Brien</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Emmet Combs - Son</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DATE SIGNED <u>12-6-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGE'S MARYLAND</u>	
23. FUNERAL DIRECTOR <u>Raymond A Ziska</u> ADDRESS <u>8434 GEORGIA AVENUE</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '61</u>			
WALTER E. PUMPHREY, INC. SILVER SPRING, MARYLAND				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14192 CERTIFICATE OF DEATH 14162									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Key West</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>29 days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>330 Duval Street</b>				
3. NAME OF DECEASED (Type or print) <b>Mary Ellen Nicholson</b>					4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>19 61</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>Caucasian</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <b>November 15, 1930</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <b>Schenectady, N.Y.</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Bryant Halsey</b>					14. MOTHER'S MAIDEN NAME <b>Emma Blaise</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>111-28-5579</b>				
17. INFORMANT <b>HUS: William Nicholson, Same as #2</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Stenosis</b> DUE TO <b>410X</b> Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic Heart Disease</b> (c) <b>16 yrs</b> DUE TO <b>7 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> e.m. p.m.									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 39, 1961</b> , to <b>Dec. 28, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 28, 1961</b> , and that death occurred <b>11:35 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>C. W. BRAM LETT LT MC USN</b> M.D.									
22b. DATE SIGNED <b>Dec. 28, 1961</b>									
22c. PHYSICIAN'S NAME (Type) <b>C. W. BRAM LETT LT MC USN</b>									
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>12-30-61</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>									
23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>									
24 FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>									
25a. REC'D BY REGISTRAR <b>JAN 2 '62</b>									
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>									

(M)

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11192

Virginia

Montgomery

Key West

29 days

Bedford (Army)

330 Dwyer Avenue

U. S. Naval Hospital

December 28,

Nicholson

Klien

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X

November 12, 1930

Caucasian

Female

USA

Schenectady, N.Y.

Honolulu

Miss Elaine

Myrtle Beach

111-28-2519 NOS: William Nicholson, same as 42

No

Stevens

Stevens

X

Nov. 30, 1931 Dec. 28, 1931

Dec. 28, 1931

Dec. 28, 1931

U. S. Naval Hospital, Boston, MA.

C. W. FIRM LEFT OF MC USN

Arlington, Virginia

Arlington National

12-30-31

Bureau

Dec. 28, 1931

Tyson Wheeler Funeral, Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14193 CERTIFICATE OF DEATH 14163											
JAN 7 10/10/62 FILED 4324-40											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>olney</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Highland</b> d. STREET ADDRESS <b>13x-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Ellen Virginia O'Brien</b> Middle Last						4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>19 61</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>8/12/1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Bowker</b>						14. MOTHER'S MAIDEN NAME <b>Cora May Golden</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia - Azotemia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Acute Chronic pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 mo</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/3 1960</b> to <b>12/6 1961</b> , that (I) (we) last saw the deceased alive on <b>12/6 1961</b> , and that death occurred at <b>6:50pm</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12/8/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Ligon</b>						22d. ADDRESS <b>Sandy Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>12-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN WHEATON.</b>		23d. LOCATION (City, town or county) (State) <b>Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>FC Rignertothorn K. Elliott City, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR <b>DEC 11 61</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>			



1933

Department

Chief

1 day

Concomery General Hospital

Allen Virginia Station

Female white

nonsexable

William Bowden

U/12/1-00

New Jersey

Cora (a) Golden

Hospital records

Mr. Charles Tison

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14194

14164

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Mont. County</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville, Md.</u>					
c. LENGTH OF STAY IN <u>7 yrs.</u>				d. STREET ADDRESS <u>Brookeville, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Carrie</u> Middle <u>Oland</u> Last <u>Oland</u>				<b>4. DATE OF DEATH</b> Month <u>DEC.</u> Day <u>26</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1872</u>			
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Fred. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>					
13. FATHER'S NAME <u>David Specht</u>				14. MOTHER'S MAIDEN NAME <u>Aurelia Kessler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Margaret O. Howes Olney Md.</u>				Address <u>  </u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic pyelonephritis</u> (c) <u>Arteriosclerosis Cerebral</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 7 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12/12/61</u> to <u>12/26/61</u> , that (I) (we) last saw the deceased alive on <u>12/26/61</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>C. H. Higon</u>				22b. DATE SIGNED <u>12/26/61</u>		22c. PHYSICIAN'S NAME (Type) <u>C. H. Higon</u>			
22d. ADDRESS <u>Sandy Spring, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, <u>Burial</u> (Specify)		23b. DATE THEREOF <u>Dec. 29 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>			

1914

STATE OF TEXAS

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14165

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 Silver Spring</b> d. STREET ADDRESS <b>14350 Good Hope Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL HUMPHREY O'LEARY</b>		4. DATE OF DEATH <b>Dec. 17 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/04</b>
9. AGE (In years last birthday) <b>57</b>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaping</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Michael O'Leary</b>	
14. MOTHER'S MAIDEN NAME <b>Julia O'Brien</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>Second W.W.216-01-9953</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO (b) <b>Rupture of aorta</b> DUE TO (c) <b>981X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> <b>Sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>Shot in chest with 22 Cal. Rifle</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>5:30 p.m. 12/17/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/18/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/21/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Haines</b>	

THE NEW YORK  
PUBLIC LIBRARY



LIBRARY OF THE  
NEW YORK PUBLIC LIBRARY

Montgomery

Olney

DOA

Montgomery General Hospital

silver spring

1430 Good Hope Rd.

WILLIAM HUNTER, O'LEARY

Dec. 17

white

1415

1/22/01

handwriting

1415

Michael O'Leary

1415 O'Leary

Second W. 1210-1211 Hospital records

Shot in chest with 22 cal. rifle

silver spring, Md.

Home

5:30 12/17/01

12/18/01

Frank L. Rosenthal

Washington National

Washington National

## CERTIFICATE OF DEATH

Reg. Dist. No.

14196

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boys--R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>10 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Hillebrand</b> First Middle Last <b>OLTHUIS</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15-1908</b>		9. AGE (In years lost birthday) yrs. <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk--Montg. Co. School Board, Md</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Holland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Tgaart Olthuis</b>				14. MOTHER'S MAIDEN NAME <b>Klaasji Van Dalen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-38-4689</b>		INFORMANT Address <b>Mrs Mary Simpson, Boys, Md. R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4 days - 6 months.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>12 Dec 1961</b> , to <b>24 Dec 1961</b> , that I lost saw the deceased olive on <b>23 Dec 1961</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>12/24/61</b>							
ACTUAL SIGNATURE <b>John Fawcett</b> M.D.				Boys, Md. R.F.D.			
PHYSICIAN'S NAME (Type) <b>John Fawcett</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Deerwood, R.F.D. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hillon</b>				ADDRESS <b>Barnesville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>William B. Hillon</b>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/58

193

Foot country

Barryland

Boston, Mass.

to the

Highland

Highland

James H. Hines

James H. Hines

Holland

Clearmont, N. J. and out board, N. J.

Alfred Van Dusen

James H. Hines

193-08-10551 Mrs. Mary Hines, Boy's, N. J.

John Hines

Flower Hill Cemetery

193-08-10551

Harrison, N. J.

Harrison, N. J.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14197

14167

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN b. <b>18 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>805 Thayer Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>805 Thayer Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Emma Irene Osbourn</b>				<b>4. DATE OF DEATH</b> Dec. 12 1961			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1881 Oct. 15, 1961</b> <b>9. AGE</b> (In years last birthday) <b>80 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Montgomery County, Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>John Boswell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Maria Clarke</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Dr. Raymond A. Osbourn</b> <span style="float: right;">Address <b>8204 Kerry Road Chevy Chase 15, Md.</b></span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Hypertensive heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>15 years</b> <b>xxix.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1961 Dec 12, 1961</b> <b>approx. 6: a.m.</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Aug. 16, 1961</b> <b>and that death occurred</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Michael J. McInerney M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Dec 12, 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Michael J. McInerney M.D.</b>				<b>22d. ADDRESS</b> <b>1150 Connecticut Avenue, N.W. Washington, D.C.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>Dec 14, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. OLIVET</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>WASH. D.C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WWTaltanull</b>				<b>ADDRESS</b> <b>3603-14th St NW (DC 10)</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 15 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>							

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH. THE DEATH CERTIFICATE IS TO BE FILLED IN BY THE ATTENDING PHYSICIAN AND CANNOT BE FILLED IN BY THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND CANNOT BE FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.



Montgomery

Silver Spring

805 Leaver Avenue

Emma

Female White

Housewife

John Boswell

None

Dr. Raymond J. Osborn

Coronary occlusion

Hypertensive heart disease

15 years  
N.H.S.

X

Aug. 16

Michael J. Clerny

W.L. ...



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
14198														
CERTIFICATE OF DEATH														
Items 4, 21, & 22b, Film G304 1/4/62 iwk 14168														
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 52 days								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 4214 Guilford Drive								
3. NAME OF DECEASED (Type or print) Suzanne (No middle name) Packard						4. DATE OF DEATH Month Day Year December 30 19 61								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1929		9. AGE (In years last birthday) 32		IF UNDER 1 YEAR Months Days				
										IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physical Therapist						10b. KIND OF BUSINESS OR INDUSTRY (Unemployed)			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harold E. Bemis						14. MOTHER'S MAIDEN NAME Hazel Mae Harwood								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 533-24-7679		17. INFORMANT The Medical Record				The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudomonas septicemia DUE TO (c) Hodgkin's Disease												INTERVAL BETWEEN ONSET AND DEATH 5 minutes 6 days 6 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 8, 1961, to December 30, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 30, 1961, and that death occurred at 10:05 P.M., from the causes and on the date stated above.														
22a. SIGNATURE Edward S. Henderson M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED January 1, 1962					
22c. PHYSICIAN'S NAME (Type) Edward S. Henderson, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/3/62		23c. NAME OF CEMETERY, OR CREMATORY Fort Lincoln Cem			23d. LOCATION (City, town or county) (State) Colmar Manor Arago, Md.						
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, INC. SILVER SPRING, MD						ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Frank				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14199 CERTIFICATE OF DEATH 14169

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sumner</b>		c. LENGTH OF STAY IN 1b <b>57</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sumner</b>		d. STREET ADDRESS <b>5011 Randall Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>LORETTA M PALMER</b>		First Middle Last		4. DATE OF DEATH <b>Dec. 26 19 61</b>		Month Day Year		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-1879</b>		9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward L. Mahoney</b>		14. MOTHER'S MAIDEN NAME <b>- - - Larkin</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - - -</b>		16. SOCIAL SECURITY NO. <b>- - - -</b>		17. INFORMANT <b>Virginia P. Mather (Daughter)</b>		Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO (b) <b>atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>- Cerebral infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>- Cerebral infarction</b>												INTERVAL BETWEEN ONSET AND DEATH																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 17, 1961</b> to <b>Dec 26, 1961</b> that (I) (we) last saw the deceased alive on <b>Dec 24, 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.												22a. SIGNATURE <b>Frank A. Finnerty, Jr. M.D.</b>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <b>Frank A. Finnerty, Jr. M.D.</b>				22d. ADDRESS <b>1150 Conn. Ave. NW. Wash. D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-28-1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hansen</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudin</b>												ADDRESS <b>1756 12th Ave NW</b>				25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hansen</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14200

## CERTIFICATE OF DEATH

14170

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eventide Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>2853 Ontario Road N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SADE D. PARTRIDGE</b>		4. DATE OF DEATH Month Day Year <b>December 24, 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/72</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days <b>47 X 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harrison Dingman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Porter Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Lloyd L. Stone</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>47 X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan 5, 1949</b> to <b>Dec 24, 1961</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Dec 24, 1961</b> , and that death occurred at <b>4:45</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas S. Sappington</b> M.D.		22b. DATE SIGNED <b>Dec. 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas S. Sappington</b>		22d. ADDRESS <b>1025 CONNECTICUT AVE. NW</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>12/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Prince Georges County, Md.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>			

THE J. E. HINCH CO., WASHINGTON, D. C.



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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Items 18&amp;2 Film 305</div> <div>1-24-62</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>14201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14171</div>													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mon</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>1 1/2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u>				d. STREET ADDRESS <u>10007 Belhaven Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10007 Belhaven Rd</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Betty Jean Patterson</u>						4. DATE OF DEATH <u>Dec 29 1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-32</u>		9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.I.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>H. M. PATTERSON</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Father</u> <u>H.M. PATTERSON</u>				Address <u>Jackson, Tenn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>888.9 Synergistic poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Pheno-barbital &amp; ethel alcohol</u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF						22c. NAME OF CEMETERY OR CREMATORY	
Burial-transit						12-30-61						Hollywood Cemetery	
23. FUNERAL DIRECTOR ROBERT A. PUMPHREY						ADDRESS Bethesda, Md.						24a. REC'D BY REGISTRAR DATE JAN 2 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna						24c. DATE JAN 2 '62						24d. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14172

21  
FOR STATE  
HEALTH DEPT.

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7500 Brookville Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>4403 39th St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clifton E Pilcher</u>		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>14</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 30, 1911</u>		<b>9. AGE</b> (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Handscaping</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Handscaping</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. C.</u>			
<b>13. FATHER'S NAME</b> <u>George H. Pilcher</u>				<b>14. MOTHER'S M maiden NAME</b> <u>Willie Mae Shent</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-038205</u>		<b>17. INFORMANT</b> <u>Charles Pilcher</u> Address <u>4403 - 39th St. Brentwood, md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> (b) <u>Coronary Occlusion</u> (c) <u>Ruptured Atheromatous Plaque</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u> <u>Sudden</u> <u>unknown</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosenz</u> M.D.				<b>DATE SIGNED</b> <u>12-14-61</u>				<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Brosenz</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Dec. 19, 1961</u>				<b>22c. NAME OF CEMETERY OR CREMATION</b> <u>Fort Lincoln Cemetery</u>				<b>22d. LOCATION</b> (City, town, or country) (State) <u>Bladensburg, Maryland.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>W. W. CHAMBERS CO.</u>				<b>ADDRESS</b> <u>517 11th St. S.E., Wash., D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 18 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Clinton L. Thomas</u>					

W. W. CHAMBERS CO. S. E. CORNER, D. C.

Jan 19, 1901

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 15th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your eyes. I hope that the treatment I have suggested will be of some benefit to you.

I am, Sir, very respectfully,  
Yours,  
W. W. Chambers

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14203

## CERTIFICATE OF DEATH

14173

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>62 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>123 W. Middle Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>Wickliff H Pollen</i>		<b>4. DATE OF DEATH</b> Dec. 14, 1961		<b>5. SEX</b> <i>M</i> <b>6. COLOR OR RACE</b> <i>W</i>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>1/24/1899</i>		<b>9. AGE</b> (In years last birthday) <i>62 yrs.</i> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Green Keeper Country Club</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Country Club</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Va</i>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA Yes</i>		<b>13. FATHER'S NAME</b> <i>Wickliff Pollen</i>					
<b>14. MOTHER'S MAIDEN NAME</b> <i>Annie Reeves</i>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i>			
<b>16. SOCIAL SECURITY NO.</b> <i>220-28-6019</i>				<b>17. INFORMANT</b> Address <i>Edith Pollen (wife) Same</i>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Ampulla of Vater + Duodenum with generalized metastases.</i> 155.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>April</i> <i>1961</i> <b>to</b> <i>Dec</i> <i>1961</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>12/13</i> <i>1961</i> , <b>and that death occurred at</b> _____ <b>M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Arthur F. Woodward</i> M.D.				<b>22b. DATE SIGNED</b> <i>12/14/61</i>			
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <i>Arthur F. Woodward</i>				<b>22d. ADDRESS</b> <i>Rockville, Maryland</i>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>12/16/61</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Frederick Memorial Park</i>			
<b>23d. LOCATION</b> (City, town or county) <i>Frederick, Maryland</i>		<b>(State)</b> _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Tyson Wheeler</i>				<b>25a. REC'D BY REGISTRAR</b> DATE <i>DEC 18 '61</i>			
<b>ADDRESS</b> <i>1331 E. Montg. Ave. Rockville, Maryland</i>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles E. Kenna</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14174

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u>			
c. LENGTH OF STAY IN lb <u>10 yr</u>				d. STREET ADDRESS <u>909 Kenbrook Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>909 Kenbrook Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Milton Aaron Brensky</u>				4. DATE OF DEATH <u>Dec 23 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1912</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Edt. research Dir. Wash-Stan</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Isaacne Brensky</u>				14. MOTHER'S MAIDEN NAME <u>Janice Thress</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>198-05-3524</u>			
17. INFORMANT <u>Elaine Brensky (wife)</u>				Address <u>Itan 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of CVA Feb 1960</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DATE SIGNED <u>12-23-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
23. BURIAL DIRECTOR <u>Douglas L. Long</u>				24a. REC'D BY REGISTRAR <u>DEC 28 '61</u>			
ADDRESS <u>3501-14 ST. N.W.</u>				24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

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IC-HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14205  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Items 13 & 23b Film 6304 12/20/61 14175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN lb <u>30 days</u>		d. STREET ADDRESS <u>1905 Lincoln Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brenda</u>		4. DATE OF DEATH <u>December 20, 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negroid</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 12, 1952</u>	
9. AGE (In years last birthday) <u>9</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Pugh</u>		14. MOTHER'S MAIDEN NAME <u>Florine Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>- - - - -</u>		Address <u>- - - - -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSSIBLE EMBOLIZATION</u> DUE TO (b) <u>SUBACUTE BACTERIAL ENDOCARDITIS</u> DUE TO (c) <u>MITRAL AND TRICUSPID REGURGITATION</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>410X</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>Nov. 20, 1961</u> , to <u>Dec. 20, 1961</u> that <u>it</u> (we) last saw the deceased alive on <u>Dec. 20, 1961</u> and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Feldman</u> M.D.		22b. DATE SIGNED <u>December 20, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. FELDMAN LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 24, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Arnold, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William Reese</u>		25c. REGISTRAR'S SIGNATURE <u>William Reese</u>	

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U.S. MARINE HOSPITAL

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U.S. MARINE HOSPITAL

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>14176</b> a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marilea Nursing Home</b>		d. STREET ADDRESS <b>16X-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nannie E. Revell</b>		4. DATE OF DEATH <b>December 25th 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Harris</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Mrs Brooks Matthews LaPlata, Md</b>	
17. INFORMANT <b>Mrs Brooks Matthews LaPlata, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Coronary Vascular Accident 4 days</b> DUE TO (b) <b>Terminal Atherosclerosis</b> DUE TO (c) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-22-1961</b> to <b>12-25-1961</b> , that (I) (we) last saw the deceased alive on <b>12-22-1961</b> , and that death occurred <b>5:10 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Rogers M.D.</b>		22b. DATE SIGNED <b>12-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John S. Rogers M.D.</b>		22d. ADDRESS <b>112 Shaw Avenue, Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/28/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St John's</b>	23d. LOCATION (City, town, or county) (State) <b>Clinton, Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>		25a. REC'D BY REGISTRAR <b>Wash 3 Dis</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 11117

14207

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4532 FAIRFIELD DRIVE</u>				d. STREET ADDRESS <u>4532 FAIRFIELD Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Truman Ridgeway</u>				4. DATE OF DEATH Month Day Year <u>December 13 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16, 1891</u>	9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto G. Ridgeway</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>420.0</u>		17. INFORMANT <u>Mrs Evelyn D. Beall</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Left Ventricular Heart Failure</u> (c) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Non-obstructive Emphysema, Chronic Cor Pulmonale</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>December 11, 1961</u> , to <u>Dec 13, 1961</u> , that I last saw the deceased alive on <u>December 13, 1961</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>915 - 19th St. N.W. Wash. D.C.</u>				DATE SIGNED <u>12/13/61</u>			
ACTUAL SIGNATURE <u>Clifton R. Gruver</u>				M.D. <u>915 - 19th St. N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Clifton R. Gruver, M.D.</u>				<u>915 - 19th St. N.W. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 16, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FREDERICK</u>	22d. LOCATION (City, town, or county) (State) <u>WARREN COUNTY VIRGINIA</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>MADDOX FUNERAL HOME</u> <u>B.R. Madrox, Jr.</u>		ADDRESS <u>FRONT ROYAL, VA.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

# DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14178

14208

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>25 mins</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>4730 Bradley Blvd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martin</b>		First <b>Also known as IRVING</b>		Middle <b>SCHACHTMAN</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH <b>Dec. 26, 1961</b>		9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>David</b>		14. MOTHER'S MAIDEN NAME <b>Narah</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Army</b>	
16. SOCIAL SECURITY NO. <b>Ross</b>		17. INFORMANT <b>Harriet Hunt - 4904 River Rd., Beth Md. (friend)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> DUE TO (b) <b>Coronary Occlusion, left Circumflex Coronary Artery</b> DUE TO (c) <b>Hemorrhage into Alheioscluotic Plaque</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-26-61</b> Address (Street, city, town, or county)					
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		M.D.			
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>12-28-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbington</b>		22d. LOCATION (City, town, or country) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR <b>Jacobs Lewis Inc 2100 Eutaw Place</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 28 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 of this Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN THE COURT



1908

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## CERTIFICATE OF DEATH

Reg. Dist. No. 14179

14209

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>21 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Hospital End Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last <u>Sabato</u>		4. DATE OF DEATH <u>12-21-61</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1899</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. UNDER 1 YEAR	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Peter Sabato, son</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, ARTERIAL</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUG. 1959</u> to <u>DEC. 21, 1961</u> , that I last saw the deceased alive on <u>DEC. 21, 1961</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.B. Snow</u> M.D.		ADDRESS (Street, city or town, state) <u>12/21/61</u>	
PHYSICIAN'S NAME (Type) <u>L.B. SNOW</u>		<u>7950 N.H. Ave. Langley Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ford Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>mt Rabin</u> DATE <u>DEC 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND NAVAL MEDICAL DEPARTMENT

12500

CERTIFICATE OF DEATH

12500

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 2 From G-305 1/17/62 iwk

14180

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>67X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda New Jersey</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CONGRESSIONAL MANOR</b>		d. STREET ADDRESS <b>9200 Wisconsin Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Katherine</b> First <b>St. Peter</b> Middle Last		4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>PATRICK MADIGAN</b>		14. MOTHER'S MAIDEN NAME <b>HANORA SHANAHAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Virginia St. Peter</b> Address <b>28 SEC Hgt 2nd 65A FT. MEADE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Coronary Artery Disease, Chronic pyelonephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>13 Oct 1958</b> to <b>10 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>10 Oct 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David A. Skel</b>		22b. DATE SIGNED <b>10 Dec 1961</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-14-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARY REST CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>DARLINGTON NEW JERSEY</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b>		25a. REC'D BY REGISTRAR <b>4812-16 Ave 210</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>DEC 13 '61</b>	

MEDICAL CERTIFICATION

TO-FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Patrick Warrigan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14211

14181

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AKLINGTON</b>	
c. LENGTH OF STAY IN 1b <b>9 days</b>		d. STREET ADDRESS <b>2347 South Nash St</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WHEATON Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PRENTISS</b> First <b>DIXON</b> Middle <b>SALE JR</b> Last		4. DATE OF DEATH <b>12 27 61</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15, 1892</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>KNOXVILLE, TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PRENTISS D. SALE SR</b>		14. MOTHER'S MAIDEN NAME <b>CAROLYN HESSEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL Hemorrhage</b> DUE TO (b) <b>hyper TENSION</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19, 1961</b> to <b>Dec 27, 1961</b> that (I) (we) last saw the deceased alive on <b>Dec. 27, 1961</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Belden R. Reap M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		22d. ADDRESS <b>11502 GRANOVIEW AVE, WHEATON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12/30/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE <b>JAN 2 '62</b>	

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BEEDEN A. REAP, M.D. 11502 EXAMINER THE DISTRICT OF  
COLUMBIA  
JUL 18 1891  
The S. R. Hines Co.  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove entire page 4 and 5 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14212

## CERTIFICATE OF DEATH

14182

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA 59</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6304 TONE DR.</u>				d. STREET ADDRESS <u>6304 TONE DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HYMAN</u> <u>SALZBERG</u>				4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 15 1893</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM SALZBERG</u>				14. MOTHER'S MAIDEN NAME <u>YETTA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>060-20-4444</u>			
17. INFORMANT <u>SAMUEL SALZBERG</u>				Address <u>8409 STEINER CT. CHEVY CHASE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC METASTASES</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CARCINOMA OF THE COLON</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 MOS</u> <u>17 MOS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 7, 1961</u> to <u>DEC 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>12/10 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J.H. Tuohy</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.H. TUOHY, M.D.</u>				22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. HEBRON</u>		23d. LOCATION (City, town or county) (State) <u>LONG ISLAND, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GOLDBERG FUNERAL HOME 4217 9TH ST NW</u>				ADDRESS <u>4217 9TH ST NW</u>		25a. REC'D BY REGISTRAR <u>DEC 13 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

28th

STATE OF NEW YORK

1891





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 23b, Film G304 1/2/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>42 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>California</b> b. COUNTY <b>La Jolla</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Jolla</b> d. STREET ADDRESS <b>PO Box 447</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Roosa Sanderson</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-82</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b>	11. IF UNDER 24 HRS. Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Sanderson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Oulahan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WIFE: Florence S. Sanderson, Same as #2</b>	
17. INFORMANT <b>WIFE: Florence S. Sanderson, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>PERIPHERAL VASCULAR COLLAPSE</b> DUE TO (b) <b>Thrombosis in distribution left middle cerebral artery</b> DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 1/2 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>2 November, 1961</b> to <b>22 December, 1961</b> , that <b>10</b> (we) last saw the deceased alive on <b>22 December 1961</b> , and that death occurred at <b>18:56 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John R. Warmolts MD</b>		22b. DATE SIGNED <b>Dec 23, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. R. WARMOLTS, LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Vir.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Kent M. Perry</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		25c. ADDRESS <b>301 W. Preston Street, Baltimore, Md.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14214

14184

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>14 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>10709 Glenwild Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>E.</b> Last <b>Sarra</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/79</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Gaertner</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Frasius</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Mr. Alvin Sarra, son same as above</b>	
17. INFORMANT <b>Mr. Alvin Sarra, son same as above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralytic Illus</b> <b>572.1</b> DUE TO <b>Diverticulitis with perforation and abscess formation &amp; Ascites</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Nephrosclerosis with uremia</b> (b) <b>Chronic Myocarditis with decompensation.</b> (c) <b>Chronic Myocarditis with decompensation.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 weeks</b> <b>Undetermined</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 16, 1961</b> to <b>Dec 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 11, 1961</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George L. Ball</b> M.D.		22b. DATE SIGNED <b>12/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George L. Ball</b>		22d. ADDRESS <b>10620 GA. AVE SIL. SP. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 15, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince George County, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Waters</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

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Montgomery

Barber

Shuman



Watts

Harris

Charles

Silver

Ed

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Watts

John

as above

*[Faint, mostly illegible handwritten notes and signatures at the bottom of the page.]*

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14215 CERTIFICATE OF DEATH 14185											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> 47X-3					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <i>2737 Devonshire Pl. N.W.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Correll Hall Sanitarium</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Wilson</i> First <i>Satterfield</i> Middle <i>Satterfield</i> Last						4. DATE OF DEATH Month <i>Dec.</i> Day <i>28</i> Year <i>1961</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/25/08</i>		9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Piano Tuner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pa.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Lawrence Satterfield</i>						14. MOTHER'S MAIDEN NAME <i>Kathryn Wilson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Helen S. Steeds</i> Address <i>505 S. Genesee Ave. Los Angeles 36, Calif.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>600.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Pyelonephritis</i> (c) <i>Generalized arteriosclerosis</i> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Old cerebral vascular episode</i>											
INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>None</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>12/26, 1961, to 12/28, 1961</i>		20g. (County) <i>Prince Georges</i>	
20h. (State) <i>Md.</i>											
21. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> , 19 <i>61</i> , to <i>12/28</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>12/28</i> , 19 <i>61</i> , and that death occurred at <i>6:35</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John B. Umhan</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John B. Umhan</i>						22d. ADDRESS <i>8805 Conn. Ave Ch. Co. Md.</i>		22b. DATE SIGNED <i>12/28/61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>				23b. DATE THEREOF <i>12/29/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Crematory</i>				23d. LOCATION (City, town or county) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>				ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i>		25a. REC'D BY REGISTRAR <i>JAN 2 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

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THE S. B. WINSTON CO.



14216

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14186

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN 1b <i>10 YRS.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-----</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FREDERICK</i> Middle <i>R</i> Last <i>SAUNDERS</i>		4. DATE OF DEATH Month <i>DEC.</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 18, 1883</i> <i>JULY 4, 1886</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>3</i> Hours <i>-----</i> Min. <i>-----</i>	11. IF UNDER 24 HRS. Hours <i>-----</i> Min. <i>-----</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>NORFOLK, VIRGINIA</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>WILLIAM T. SAUNDERS</i>	
14. MOTHER'S MAIDEN NAME <i>ROSELLE WINNINGER Winingder</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>224-26-1139</i>		17. INFORMANT <i>MISS EDITH SAUNDERS, SAME AS 2D, DAUGHTER</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma left upper lung</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>-----</i> DUE TO (c) <i>-----</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-----</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>-----</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1948</i> to <i>Dec 7, 1961</i> that (I) <i>(no)</i> last saw the deceased alive on <i>Dec 7, 1961</i> and that death occurred at <i>10</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Saul Holtzman</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Saul Holtzman</i>		22d. ADDRESS <i>1800 E 4c St. NW Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE THEREOF <i>12/8/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CREMATORY</i>	23d. LOCATION (City, town, or county) (State) <i>BLADENSBURG, MARYLAND</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Bawlers Sons, 1752 Piquette</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 11 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Funn</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14217											
14187											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>11 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>60 Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>8001 Bradley Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas R. Scanlan</b>				4. DATE OF DEATH <b>12/27/61</b>				5. AGE (In years last birthday) <b>62 yrs.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 16, 1899</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Industrial Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Indx Engineer</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Arthur Andrew L.</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Lingo</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-03-1601</b>				17. INFORMANT <b>Dorothy - wife</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>157X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Phlebitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Rockville, Maryland</b>				20g. (County) <b>Montgomery</b>				20h. (State) <b>Md</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>12/11/61</b> to <b>12/27/61</b> , that (I) (we) last saw the deceased alive on <b>12/27/61</b> , and that death occurred at <b>10:30 P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr Joseph Kenrick</b>				22b. DATE SIGNED <b>12/28/61</b>				22c. PHYSICIAN'S NAME (Type) <b>Dr JOSEPH KENRICK</b>			
22d. ADDRESS <b>6450 Wisconsin Ave, Bethesda, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/2/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			
23d. LOCATION (City, town or county) <b>Rockville, Maryland</b>				23e. REC'D BY REGISTRAR <b>JAN 2 '62</b>				23f. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14218 CERTIFICATE OF DEATH 14188											
1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>two weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1701 Pricilla Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Louis Brooks Schneider</u>						4. DATE OF DEATH <u>December 17 19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>			
13. FATHER'S NAME <u>Louis H. Schneider</u>						14. MOTHER'S MAIDEN NAME <u>Adele Brooks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Flourney C. Schneider</u>						1353 11th Street, N.W. Washington D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS L. MIDDLE CEREBRAL ARTERY</u> 410X DUE TO <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>MITRAL INSUFFICIENCY</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>2 YRS.</u> <u>10 YRS.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-17 1961</u> to <u>12-17 1961</u> , that (I) (we) last saw the deceased alive on <u>12-17 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>LEE B. SNOW</u>						22b. DATE SIGNED <u>12/17/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>LEE B. SNOW</u>						22d. ADDRESS <u>7950 NEW HAMPSHIRE AVE., LANGLEY PARK, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Memorial Cemetery Arlington, New Jersey</u>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey</u>	

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**THE UNIVERSITY OF CHICAGO**



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14219

14189

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>2511 Que St N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leona Elizabeth Schoyer</u>			<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>24</u> Year <u>1961</u>				
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-7-1891</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Louis Schoyer</u> 14. MOTHER'S MAIDEN NAME <u>Leona Beavers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Ovary with metastases</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>12/13, 1961</u> , to <u>12/24, 1961</u> , that (I) (we) last saw the deceased alive on <u>12/23, 1961</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Michael R. Dobridge M.D.</u>			22b. DATE SIGNED <u>12/24/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>			22d. ADDRESS <u>10620 GEORGIA AVE SILVER SPRING MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemt.</u>			
23d. LOCATION (City, town or county) <u>Washington, D.C.</u>		23e. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <u>Joseph F. BIRCH'S SONS Washington, D. C.</u>			25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>Clifton L. Evans</u>			25c. _____				

MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b> d. STREET ADDRESS <b>1610 Erskine Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Joan Dawn Schuster</b>						4. DATE OF DEATH <b>December 30 19 61</b>						5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Typist</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Government Agency</b>						11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>											
13. FATHER'S NAME <b>Francis X. Schuster</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Uzonyl</b>						17. INFORMANT <b>The Medical Record</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>579-52-3420</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Failure and Acute Pulmonary Edema</b> DUE TO (b) <b>Right lower lobe pneumonia and bleeding from GI tract. 4 days</b> DUE TO (c) <b>Disseminated lupus Erythematosus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 years</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)						21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 27, 1961</b> to <b>December 30, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 30, 1961</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.						22b. DATE <b>December 30, 1961</b>											
22a. SIGNATURE <b>Mark W. Bitensky</b>						22c. PHYSICIAN'S NAME (Type) <b>Mark W. Bitensky, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF <b>JAN 3 1962</b>						23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL CEM. ARLINGTON VA.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Finna</b>						25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finna</b>											



Handwritten text, likely bleed-through from the reverse side of the page, mentioning "Handwritten text" and "Handwritten text".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14221

14191

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>		75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>5300 Orchard Hill Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jean Paulette Schwartz</u>				4. DATE OF DEATH Month Day Year <u>December 13, 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 11, 1943</u>	
9. AGE (In years last birthday) <u>18 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Paul Schwartz</u>				14. MOTHER'S MAIDEN NAME <u>Regina Conway</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
17. INFORMANT <u>The Medical Records</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral Valve Insufficiency</u> DUE TO (c) <u>Congenital Heart Lesions</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>18 years</u> <u>18 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 10, 19 61</u> to <u>December 13, 19 61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 10, 19 61</u> , and that death occurred at <u>4:55 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Kenneth L. Melman M.D.</u>				22b. DATE SIGNED <u>December 14, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Kenneth L. Melman, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		23b. DATE THEREOF <u>12/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Allegheny County</u>		23d. LOCATION (City, town or county) (State) <u>Pittsburgh, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 21 61</u>		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

1931

1931



Robert A. Rosenberg, Bethesda, Maryland

Official - Transmittal 12/15/51

Kenneth J. Nelson, M.D.

October 13, 1951

December 13, 1951

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14222

14192

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>30 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Claxton</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>49X-3</u> d. STREET ADDRESS <u>P.O. Box 426</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Susan</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>December 6, 1961</u> Month Day Year		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>December 21, 1956</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Georgia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>13. FATHER'S NAME</b> <u>Lawton D. Scott</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Loretta Barrow</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>The Medical Records</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Septicemia, probably staphylococci</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Acute lymphocytic leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>November 6, 1961</u> to <u>December 6, 1961</u> that (I) (we) last saw the deceased alive on <u>December 6, 1961</u> , and that death occurred at <u>1:55 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Thorne S. Winter, III</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thorne S. Winter, III, M.D.</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</u> <b>22b. DATE SIGNED</b> <u>12/6/61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/7/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brewton Cemetery</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 8 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(P)

Robert A. Humphrey, Bethesda, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 14193

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Bethesda</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery County</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>16416 Tudorale Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SEEBACK</u> Last <u>—</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months <u>14</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry P. Seebach</u>		14. MOTHER'S MAIDEN NAME <u>Jean E. Cissel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Harry P. Seebach</u> Address <u>2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>757.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart - Cerebral Palsy Birth</u> (c) <u>Hydrocephalic Kidney - Glaucoma Birth</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		20g. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>8-26-1961</u> , to <u>12-10-1961</u> , that I last saw the deceased alive on <u>12-10-1961</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert D. Cowley</u> M.D. <u>5506</u>		ADDRESS (Street, city or town, state) <u>from Ave. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cemetery</u>	22d. LOCATION (City, town, of county) (State) <u>Georgetown PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>		24a. REC'D. BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14224

## CERTIFICATE OF DEATH

14194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5404 Western Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH</u> <u>E. BOND</u> <u>SHOEMAKER</u>		4. DATE OF DEATH Month Day Year <u>12</u> <u>11</u> <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/88</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Bond</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Harlan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-48-2722</u>	
17. INFORMANT <u>Donald Shoemaker</u>		Address <u>4707 Weyanconder Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes mellitus duodenal ulcer</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> <u>1961</u> , to <u>12/11</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> <u>1961</u> , and that death occurred at <u>4:52 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. L. Marks</u>		22b. DATE SIGNED <u>12-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. L. MARKS, M.D.</u>		22d. ADDRESS <u>6306 Wisconsin Ave. Ch. Ch. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/14/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Elderbrook Church Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>DEC 15 61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>	

1833

CERTIFICATE OF DEATH

1833

Robert A. Pugh, Sergeant, Maryland  
Buried 12/14/01 Elderbrook Church Cem. Washington, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14225

14195

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>06 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium</b>		d. STREET ADDRESS <b>12200 Stoney Creek Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katharine Danforth Shriver</b>		4. DATE OF DEATH Month Day Year <b>December 26 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Unknown) Danforth</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Louise S. Douglass-Daughter-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Failure</b> (c) <b>Bronchopneumonia and Cerebrovascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>78 hr</b> <b>22</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1961</b> to <b>Dec 26 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 26 1961</b> , and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. H. KILIA</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>W. H. KILIA</b>		22d. ADDRESS <b>8218 Wisconsin Ave Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-28-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert D. Pumphrey-Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 2 '62</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14196

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Manassas</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>109 Perce St.</b> d. STREET ADDRESS <b>109 Perce St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rochelle Marie Simond</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>6</b> Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roger Comile Simond</b>		14. MOTHER'S MAIDEN NAME <b>Ofelina Hernandez</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father Roger Comile Simond Same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, Acute lymphocytic</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Dec. 26</b> , 1961 to <b>Dec. 26</b> , 1961, that <del>he</del> (we) last saw the deceased alive on <b>Dec. 26</b> , 1961, and that death occurred at <b>10:55 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>L.P. Scott</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>L.P. SCOTT, LCDR MC USN</b>		22b. DATE SIGNED <b>12-27-61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>30 Dec 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Baker and Son Funeral Home</b> ADDRESS <b>Baker and Son Funeral Home, Manassas, Virginia</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruza</b>	



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L.P. COIT, LCMC USN

Almond, Virginia

Almond, Virginia

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Female

Almond, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14227

14197

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Romney c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) None d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) Jennifer First Ann Middle Solan Last		<b>4. DATE OF DEATH</b> Month December Day 28 Year 19 61	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> 1 October 1961	<b>9. AGE</b> (In years last birthday) 2 yrs. 27 Months 27 Days <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Infant
<b>11. BIRTHPLACE</b> (County & State, or foreign country) Virginia		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> George M. Solan		<b>14. MOTHER'S MAIDEN NAME</b> Marjorie Sonnenann	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No		<b>16. SOCIAL SECURITY NO.</b> None	
<b>17. INFORMANT</b> The Medical Record, The Clinical Center, Bethesda 14, Maryland		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease (Tricuspid atresia) 2 mo. 27 days (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that</b> (this hospital) attended the deceased from December 20, 1961 to December 28, 1961, that (I) (we) last saw the deceased alive on December 28, 1961, and that death occurred at 10:20 AM, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> Richard P. Anderson M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) Richard P. Anderson		<b>22b. DATE SIGNED</b> December 28, 1961 <b>22d. ADDRESS</b> The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial-transit 12-28-61		<b>23b. DATE THEREOF</b> 12-28-61	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Mt. Olivet Cemetery		<b>23d. LOCATION</b> (City, town or county) (State) Moorefield, W. Va.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ROBERT A. PUMPHREY		<b>25a. REC'D BY REGISTRAR</b> DATE JAN 2 '62	
<b>ADDRESS</b> Bethesda, Md.		<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kinne	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14228						14198					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)					
e. COUNTY <u>Montgomery</u>						e. STATE <u>D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
c. LENGTH OF STAY in 1b <u>27 weeks</u>						d. STREET ADDRESS <u>6151 31st N.W.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <u>Margaret B Somerville</u>						Month Day Year <u>Dec 16 1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-10</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bogley, Harting</u>				11. BIRTHPLACE (County & State, or foreign country) <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. Harry Borjes</u>						14. MOTHER'S MAIDEN NAME <u>Teobbits Cardwell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Son S -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the cervical glands of the right side of neck</u>											
198.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u>											
(c) <u>—</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>Dec 1961</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>16 Dec 1961</u> and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Herbert Martyn Jr</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>16 Dec 61</u>		
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>						22d. ADDRESS <u>5029 Bethesda Ave, Beth. Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>12-19-1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler, Jr</u>						ADDRESS <u>1756 PENNSYLVANIA AVE. WASH. D.C.</u>			25a. REC'D BY REGISTRAR <u>DEC 22 '61</u>		
									25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

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A. Harry Bortles Tobacco Cord Well

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Measurements of the corners  
of the right side of neck

15 Dec 01 June 1985 Dec 01

HERBERT MARTIN JR 2021 BETTENDEN AVE B. W. M.  
X 10 Dec 01

Gravestone 12-10-1981 Cedar Hill Cemetery, Arlington, MA.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14229

14199

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5307 42nd. St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>B</b> Last <b>Spence</b>				4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/27/76</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b>		IF UNDER 24 HRS. Hours <b>85</b> Min. <b>85</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>John Henry Spence</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Stone</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Neice, Theresa Spence, same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial decompensation with pulmonary edema</b> DUE TO (b) <b>Myocardial degeneration, chronic</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Padgett's disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>One year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>Dec 22, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>December 21, 1961</b> , and that death occurred at <b>949 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stewart Clapp</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12.22.61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>				22d. ADDRESS <b>4740 Cherry Chase Dr. Ch. Ch. 15 Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Washington DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b>				ADDRESS <b>5103 Wise Ave</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

any delay is necessary, the funeral director, Page 5 may be retained for your files. With the State Board of Health, in any event within 72 hours after death.

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MEDICAL CERTIFICATION

<div> <div> <div>14230</div> <div>14200</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>5035 Bradley Boulevard</u>							
3. NAME OF DECEASED (Type or print) <u>Russell E. Stanford II</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1961</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7 1961</u>		9. AGE (In years last birthday) <u>5</u> Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Russell E. Stanford</u>				14. MOTHER'S MAIDEN NAME <u>Donna Covey</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Russell E. Stanford-father-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral contusions and lacerations</u> DUE TO <u>Fracture skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Automobile accident</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>"</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Passenger in car involved in accident</u>							
20c. TIME OF INJURY Month, Day, Year <u>12-26 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-26-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Prince George Co. Md.</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14231

14201

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> <b>13 1/2 days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> <b>1646-2</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3370 Chillum Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph (N.M.N.) Startari</b>		4. DATE OF DEATH <b>December 24 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Newstand) Operator Newstand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Italy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13. FATHER'S NAME <b>Vitale Startari</b>		14. MOTHER'S MAIDEN NAME <b>Florence Bacqua</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war/dates of service)		16. SOCIAL SECURITY NO. <b>Chart</b>	
17. INFORMANT <b>Chart</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA WITH PULMONARY CONGESTION AND EDEMA</b> DUE TO (b) <b>4-93X</b> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>POST OPERATIVE STATUS FROM CARCINOMA OF THE BLADDER</b> DUE TO (d) <b>12 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <b>several days</b>	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.		22a. SIGNATURE <b>Arthur J. White</b> M.D.	
22b. PHYSICIAN'S NAME (Type) <b>Arthur J. White</b>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>Dec 24-1961</b>	
22d. ADDRESS <b>Chart</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Dec 27, 1961</b>		23c. NAME OF CEMETERY OR CREMATOR <b>George Washington</b>	
23d. LOCATION (City, town or county) <b>Hyattsville, Md.</b>		23e. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24b. ADDRESS <b>Hyattsville Md.</b>	
25a. REC'D BY REGISTRAR <b>Jan 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January", "February", "March", "April", "May", "June", "July", "August", "September", "October", "November", "December" are faintly visible, suggesting a calendar or ledger.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January", "February", "March", "April", "May", "June", "July", "August", "September", "October", "November", "December" are faintly visible, suggesting a calendar or ledger.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January", "February", "March", "April", "May", "June", "July", "August", "September", "October", "November", "December" are faintly visible, suggesting a calendar or ledger.

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14232 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park D.O.A.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>27 Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash SAN + Hosp.</b>				d. STREET ADDRESS <b>1902 Rosemary Hills Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>G. J. Man</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-15-82</b> last birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES Selby</b>				14. MOTHER'S MAIDEN NAME <b>Alverda McKnew</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MR Charles W Stewart - Son</b> Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
23. FUNERAL DIRECTOR <b>Raymond A. Ziska</b> ADDRESS <b>8434 Georgia Avenue</b>				24a. REC'D BY REGISTRAR <b>DEC 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
22d. LOCATION (City, town, or country) (State) <b>Washington D.C.</b>				22e. ADDRESS (Street, city, town, or county) <b>Silver Spring, Maryland</b>			

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MEDICAL CERTIFICATION

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THE UNIVERSITY OF CHICAGO  
LIBRARY

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FOR STATE  
HEALTH DEPT.

any delay is necessary, the funeral director, Page 5 may be retained for your files, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14233

14203

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence, or place of admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>CARBOLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				e. STREET ADDRESS <b>RT#1</b>			
3. NAME OF DECEASED (Type or print) <b>Lionel</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-13-1901</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ridgely Const. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Henry B. Stickles</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Furr</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>202-18-6909</b>		17. INFORMANT <b>Lionel E. Stickles Jr. Manchester Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Thoracic hemorrhage</b> DUE TO (b) <b>rupture of heart</b> DUE TO (c) <b>struck by crane</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by crane</b>			
20c. TIME OF INJURY Month, Day, Year <b>8:25 P.M. 12-13 1961</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Construction job</b>		20f. (City or town) (County) (State) <b>Bethesda Monty Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Brochart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE THEREOF <b>12-16-61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22d. LOCATION (City, town, or country) (State) <b>Towson Maryland</b>			
23. FUNERAL DIRECTOR <b>Brooks Funeral Service Towson Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 15 '61</b>			
				24b. REGISTRAR'S SIGNATURE <b>Clifford S. Kraus</b>			

STATE  
DEPARTMENT

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VERMONT

Liberty Bond, Co.

Form

Henry J. Burdette

State of

UNKNOWN UNKNOWN 205-15-5000 Liberty & Stickland W. Burdette

Brooks Funeral Service  
1-15-11  
Tombstone Hill  
Tombstone Hill



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14234											
14204											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>10810-Keller St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bulah Lee Swadley</u>						4. DATE OF DEATH Month Day Year <u>Dec. 21 19 61</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/09</u>		9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>4 7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Truman Kiser</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Virginia Reprod.</u>				17. INFORMANT <u>Carl Swadley</u> Address <u>Same As Above.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21, 1961</u> to <u>Dec. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 21, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Belden R. Reap M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>						22d. ADDRESS <u>WHEATON, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-trans</u>		23b. DATE THEREOF <u>12/22/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sugar Grove Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Sugar Grove, West Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey Bethesda, Maryland</u>						ADDRESS —		25a. REC'D BY REGISTRAR DATE <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

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Statement of Return

ROBERT A. THOMPSON, M.D., WESTERN, MARYLAND

Bureau - 12/30/1961 Sweet Grove Cemetery Sweet Grove, West Virginia

Robert A. Thompson Bethesda, Maryland

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11209  
14235  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>20 minutes</u>				d. STREET ADDRESS <u>8820 - River Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Swain</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/61</u>	
9. AGE (In years last birthday) <u>24m</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>10</u> Hours <u>30</u> Min. <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Freemont Swain</u>				14. MOTHER'S MAIDEN NAME <u>Helen Ann Cunningham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mother's chart -</u>			
17. INFORMANT <u>Mother's chart -</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>752X</u> DUE TO <u>ANOXIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>HYDROCEPHALUS</u> (a), stating the underlying cause last. DUE TO <u>CONGENITAL MALFORMATION</u> (c) <u>DEVELOPMENTAL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SPINAL MENINGOCELE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>DEVELOPMENTAL</u> <u>DEVELOPMENTAL</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/10, 1961</u> to <u>12/10, 1961</u> , that (I) (we) last saw the deceased alive on <u>12/10, 1961</u> , and that death occurred at <u>6:43 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles J. Savarese</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE MD</u>				22d. ADDRESS <u>4890 BATTERY LANE BETHESDA MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 13 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thorne</u>	

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Robert A. Humphrey, Bethesda, Maryland

Burial 12/12/61

Gate of Heaven Cem.

Silver Spring, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14236					14206				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Montgomery</b>					a. STATE <b>West Virginia</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					b. COUNTY <b>Charleston</b>				
c. LENGTH OF STAY IN 1b <b>21 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1552 Bridge Road</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>					d. STREET ADDRESS <b>1552 Bridge Road</b>				
3. NAME OF DECEASED (Type or print) <b>Frederica (None) Talbot</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>April 25, 1904</b>				
9. AGE (In years last birthday) <b>57 yrs.</b>					10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frederick Dalzell</b>					14. MOTHER'S MAIDEN NAME <b>Mary Peyton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>Unavailable</b>				
17. INFORMANT <b>The Medical Record</b>					Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Pyelonephritis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a) <b>Metastatic Breast Carcinoma</b> b) <b>Status post-hypophysectomy</b> c) <b>Bone marrow depression secondary to chemotherapy.</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (a) (this hospital) attended the deceased from <b>December 4, 1961</b> to <b>December 25, 1961</b> that (b) (we) last saw the deceased alive on <b>December 25, 1961</b> , and that death occurred at <b>6:45 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Michael Field</b>									
22b. DATE SIGNED <b>December 26, 1961</b>									
22c. PHYSICIAN'S NAME (Type) <b>Michael Field, M.D.</b>									
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>12/28/1961</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews,</b>									
23d. LOCATION (City, town or county) (State) <b>Charleston, West Virginia</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>									
ADDRESS <b>Bethesda, Maryland</b>									
25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>									
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>									

Robert A. Murphy, Bethesda, Maryland

12/23/1961 St. Matthews,

Charleston, West Virginia

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December 23, 1961

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TO-HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO-GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/59

14237

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14207

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b <b>36 Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10815 Madison Street</b>				d. STREET ADDRESS <b>1 10815 Madison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b>		First <b>Jordan</b>		Middle <b>Taylor</b>		Last <b>December 7 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1896</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architect</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Frank C. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Anna B. Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I</b>		17. INFORMANT <b>Margarett Taylor-Wife-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1954</b> to <b>12-7-1961</b> that (I) (we) last saw the deceased alive on <b>12-7-1961</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>George Sharpe</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>12-8-61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe M.D.</b>				22d. ADDRESS <b>10511 Summit Ave. Kensington Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

(M)

(I)

THE UNIVERSITY OF CHICAGO PRESS

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14238

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>olney</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution, Resident, (for admission) e. STATE <b>D.C.</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> g. STREET ADDRESS <b>4057 Grant St. N.E.</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Woodson</b> Last <b>Terrell</b>			4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>61</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/26/15</b>		9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>8</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>Charley Terrell</b>			14. MOTHER'S MAIDEN NAME <b>Cornelia Duke</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Not stated</b>		
17. INFORMANT <b>Grace Terrell - 4067 Grant St. NE. (wife)</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal hemorrhage</b> <b>825X</b> DUE TO <b>Rupture of liver (marked)</b> Conditions, if any, which gave rise to immediate cause (b) <b>Due to</b> (c) <b>Due to</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chest (st)</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Driver of car involved in accident.</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year <b>12/8/61</b> Hour, m., a.m. <b>12:05am</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
20f. (City or town) <b>silver spring, Montg. Md.</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>12/8/61</b>		
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-12-61</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or country) <b>Virginia</b>		22e. (State)			
23. FUNERAL DIRECTOR <b>Drazier's Funeral Home, 384-RD. Ave. 7-10</b>			ADDRESS <b>DC.</b>		
24a. REC'D BY REGISTRAR <b>DEC 12 61</b>			24b. REGISTRAR'S SIGNATURE <b>Wm. S. Thomas</b>		
DATE					

MEDICAL CERTIFICATION

51

1. (a) 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14239

14209

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederic</b> Middle <b>L.</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13. FATHER'S NAME <b>Alban Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Sue Leggett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>5 wks.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov.</b> , 19 <b>59</b> , to <b>Dec.</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 31</b> , 19 <b>61</b> , and that death occurred at <b>5:15 P.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. Bonifant</b>		22d. ADDRESS <b>Sandy Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friends Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 '62</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

(M)

(1)

name	white	W	January 29, 1878	82
Ranker	Ranking		Maryland	United States
Alban	Thomas		the request	
unknown	Thomas		hospital records	

Franklin D. Porter, Louisville, Mo.  
Jan. 2, 1908  
Franklin Cemetery



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14240  
CERTIFICATE OF DEATH  
14211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>20 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>116 Park Ave.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Maude Elizabeth Thompson</u>		4. DATE OF DEATH <u>12 - 31 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-27-07</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Walter Gregg</u>				14. MOTHER'S MAIDEN NAME <u>Cora Norris</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hosp. Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>12/30/61</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9/24/55</u> to <u>Dec. 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 31, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Howard T. Morse</u>				22b. DATE SIGNED <u>12/31/61</u>				22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				22d. ADDRESS <u>7030 Carver Ave Takoma Park, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 4, 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				24b. ADDRESS <u>254 Carroll St. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Morris</u>							

(M)

(1)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1944" and "RECEIVED" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14241

14210

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>5da 15 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>733 Sligo Avenue, Apt. 615</b> <b>1230 PLEASANT PARK DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Viola Deane Thomson</b>		4. DATE OF DEATH Month Day Year <b>December 2 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>November 13, 1880</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office Dept</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Belford</b>		14. MOTHER'S MAIDEN NAME <b>Anna Heffelfinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Record.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b> <b>153.1</b> DUE TO (b) <b>PRIMARY ADENOCARCINOMA, TRANSVERSE COLON - 15 MO.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH - 15 MO.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Dec 2, 1958</b> to <b>2 Dec., 1961</b> , that (I) (we) last saw the deceased alive on <b>2 Dec., 1961</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lemuel T. Kimble</b>		22b. PHYSICIAN'S NAME (Type) <b>SERUCH T. KIMBLE</b>		22c. ADDRESS <b>927 Pleasant Dr., Silver Spring, Md.</b>	
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/>		22f. DATE <b>DEC 5 '61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Montgomery Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond H. Ziska</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. ADDRESS <b>8434 Georgia Avenue</b>		25d. CITY, STATE, ZIP <b>Silver Spring, Maryland</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

2

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14242 CERTIFICATE OF DEATH 14212											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 111 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shamokin			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				Last 142 South Franklin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stephen Lawrence Tighe				4. DATE OF DEATH December 25, 1961				9. AGE (In years if under 1 year, if under 24 hrs.) 51 yrs. 4 months 23 days			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1910		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipper and Checker		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME John J. Tighe				14. MOTHER'S MAIDEN NAME Mary Martin				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 178-05-1163				17. INFORMANT The Medical Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Thyroid gland metastatic to lungs, liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure of unknown etiology DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 years 4 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from September 5, 1961 to December 25, 1961 that (X) (we) last saw the deceased alive on December 25, 1961, and that death occurred at 4:00 AM from the causes and on the date stated above.											
22a. SIGNATURE Carl J. Bantzel				M.D. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				22b. DATE SIGNED December 26, 1961			
22c. PHYSICIAN'S NAME (Type) Carl J. Bantzel, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/29/1961		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town or county) Coal Township Penna.		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR DEC 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Robert A. Pamprey, Maryland

12/25/1981 St. Mary's

Coal Township, Penn.

Car. 1, 1981

of health, Maryland, 1981

December 15, 1981

December 15, 1981

The National Center for  
Environmental Health  
Effects Research  
1000 North 17th Street  
P.O. Box 12187  
Raleigh, NC 27605



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50

I

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14243											
14213											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>40 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>Papillion</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>310 Crest Road</b> d. STREET ADDRESS <b>648-3</b>					
3. NAME OF DECEASED (Type or print) <b>Michael Laverne Timmerman</b>						4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 23, 1954</b>		9. AGE (In years last birthday) <b>7 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Laverne Timmerman</b>						14. MOTHER'S MAIDEN NAME <b>Patricia McCormick</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>The Medical Records</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 200-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Probable Hypoglycemia</b> (a), stating the underlying cause last, (c) <b>Lymphosarcoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>metastases to mediastinum, liver, bone marrow.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 23, 1961</b> to <b>December 2, 1961</b> that (I) (we) last saw the deceased alive on <b>December 2, 1961</b> , and that death occurred at <b>9:25 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>J. David Heywood</b>						22b. DATE <b>12-2-61</b>					
22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 12-3-61</b>				23b. DATE THEREOF <b>12-3-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Papillion Cemetery</b>			
23d. LOCATION (City, town or county) <b>Papillion, Nebraska</b>				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>						25a. REC'D BY REGISTRAR <b>BAG 6 '61</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>											

1923



ROBERT A. PUMPHREY Bethesda, Maryland

Official-Transcript 1923-24 Rabbits Cemetery

Section of Rabbits Cemetery, Bethesda, Maryland

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

Section 2, Block 2, Lot 2, 1923-24

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

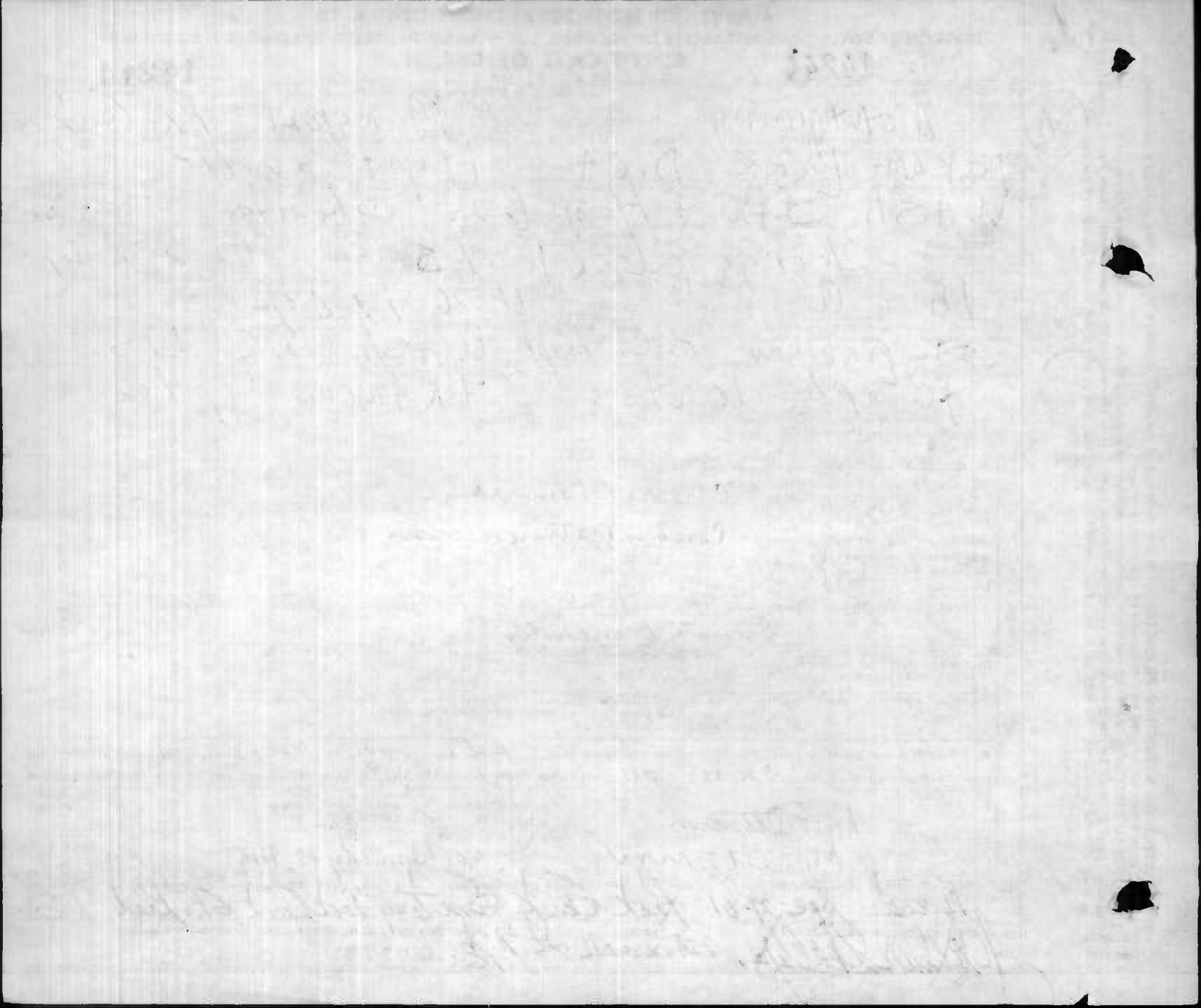
14244

14214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 11522</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash SAN + Hosp</u>			e. STREET ADDRESS <u>625 Sheridan St</u>		
3. NAME OF DECEASED (Type or print) <u>George Edgar Towles</u>			4. DATE OF DEATH <u>12-23 1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-97</u>		9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. Dept WASH D.C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Towles</u>			14. MOTHER'S MAIDEN NAME <u>FRANCES Upton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>		
17. INFORMANT <u>(Address)</u>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>					
331X DUE TO (b) <u>Cerebral atherosclerosis</u>					
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <u>Sabute bronchitis</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>61</u> , to <u>Dec 23</u> , 19 <u>61</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Dec 21</u> , 19 <u>61</u> , and that death occurred at <u>330 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>M. F. OTTMAN</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>		22d. ADDRESS <u>401 Kennedy St NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>Dec-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City, town or county)	(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Kelly</u>		ADDRESS <u>254 Carroll St. N.E.</u>		25a. RECD BY REGISTRAR <u>DEC 27 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kelly</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14245

14215

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>olney</b>		c. LENGTH OF STAY IN 1b <b>4 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		d. STREET ADDRESS <b>Norwood Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Curt</b>		First Middle Last <b>Von Seydlitz</b>		4. DATE OF DEATH Month Day Year <b>December 13 1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1872</b>	
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give number or date of service) <b>Yes</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA BILATERAL</b> 491X Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , 19 <b>61</b> , to <b>12/13</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>61</b> , and that death occurred at <b>11</b> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Luciano I. Leal</b>				M.D. <b>LUCIANO I. LEAL, M.D.</b> <b>XXXXXXXXXXXXXXXXXXXX</b>		22b. DATE SIGNED <b>12/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LUCIANO I. LEAL, M.D.</b>				22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 18 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

ATLANTA, GEORGIA  
BIRMINGHAM, ALABAMA



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14216											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						b. COUNTY Prince Georges					
c. LENGTH OF STAY IN 1b 63 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 2609 Kirkwood Place					
3. NAME OF DECEASED (Type or print) Alice Dorothy Walling						4. DATE OF DEATH December 18 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 4, 1916		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME William W. Giles						14. MOTHER'S MAIDEN NAME Gertrude Fields					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 218-20-2343					
17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Embolus with brain damage (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8 Hours 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease - Mitral Stenosis with left atrial thrombus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (X) (this hospital) attended the deceased from October 16, 1961 to December 18, 1961, that (X) (we) last saw the deceased alive on December 18, 1961, and that death occurred at 11:40 AM from the causes and on the date stated above.											
22a. SIGNATURE Paul A. Ebert						22b. DATE SIGNED 12/18/61					
22c. PHYSICIAN'S NAME (Type) Paul A. Ebert, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) Suitland, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons						ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR DATE DEC 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

(M)

(I)

Francis Gascara's Sons Hyattsville, Maryland

General 1 12/21/51 Cedar Hill

Emiliando, Maryland

Wm. A. Moore, Jr.

I enclose 2 copies of the Clinic's report, dated 12/14/51.

12/14/51

11:10

Re: Francis Gascara's Sons - 12/14/51 - 11:10

x

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14247

14217

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>1 mo &amp; 13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 29</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>				d. STREET ADDRESS <b>1234 DALE DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEONARD GRIFFITH WALLIS</b>				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-80</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOUTHERN RAILWAYS ET. SO. RAILWAYS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>2nd, MONTGOMERY COUNTY</b>		11. BIRTHPLACE (Country and state or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM H. WALLIS</b>				14. MOTHER'S MAIDEN NAME <b>MARIA GRIFFITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>718-10-5746</b>		17. INFORMANT <b>HOSPITAL CHART-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia - Arteriosclerotic Heart Disease</b> 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>4-20-61</b> (a), stating the underlying cause last. DUE TO (c) <b>4-20-61</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Generalized Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>APRIL, 1960 to Dec. 5, 1961</b>		(County) (State)	
21. I certify that (I) (this Hospital) attended the deceased from <b>April, 1960</b> to <b>Dec. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 4, 1961</b> , and that death occurred at <b>4:13 AM</b> from the causes and on the date stated above.							
22. SIGNATURE <b>J. Marion Bankhead</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>				22d. ADDRESS <b>9241 Col. Blvd. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>DEC 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14248 CERTIFICATE OF DEATH 14218											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN lb <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b> d. STREET ADDRESS <b>none</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Nona Burns Warthen</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 61</b>							
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/19/1883</b>		9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days <b>19 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>				11b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Clifford Burns</b>				14. MOTHER'S MAIDEN NAME <b>Roseanna Glaze</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>217 28 6033</b>				17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Compression fracture T-9+12</b> (c) <b>Arteriosclerosis, Generalized</b> DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis, Generalized</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Patient fell out of bed, at home</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient fell out of bed, at home</b>							
20c. TIME OF INJURY Month, Day, Year <b>12-14 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20f. (City or town) <b>Gaithersburg</b>				20g. (County) <b>Mont.</b>				20h. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 15, 1961</b> to <b>Dec. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>12-24-1961</b> , and that death occurred at <b>12-26-1961</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Jack Schumacker</b>				22b. PHYSICIAN'S NAME (Type) <b>Jack Schumacker</b>				22c. ADDRESS <b>Gaithersburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Dec. 28 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Damascus</b>			
23d. LOCATION (City, town or county) <b>Damascus</b>				23e. (State) <b>Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 29 '61</b>			
								25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>			



Lyonsville, Va.

April 28 1951

Parents

Lyonsville

Jack Schumaker

Calithersburg



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14249

14219

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8658 Piney Branch Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Hillian</u> <u>Allie</u> <u>Weaver</u>		<b>4. DATE OF DEATH</b> Last <u>Dec</u> Month <u>12</u> Day <u>19</u> Year <u>61</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-16-1891</u>		<b>9. AGE</b> (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Civil Service</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. govt</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>NEWTON</u> <u>XXXXXXXXXXXX</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary S. Benson</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>*****</u>				<b>17. INFORMANT</b> <u>Hospital Records</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis Acute</u> DUE TO (b) <u>Hypertensive Heart Disease</u> (a), stating the underlying cause last. (c) <u>Hypertension</u>												INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>9-23-</u> <u>1961</u> , to <u>12-12-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12-11-</u> <u>1961</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Sam Hillman</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>12/12/61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>SAMUEL A. HILLMAN</u>				<b>22d. ADDRESS</b> <u>8829 Flower Ave. S.S. Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince Georges Maryland</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner B. Pumphrey, Inc.</u>				<b>ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 15 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>			

(M)

Hypertension  
Hypertensive Heart Disease  
Coronary Thrombosis Acute

8829 Flower Ave. S.W.  
12-11-61  
12-12-61  
12-13-61

Samuel A. Hillman  
12-11-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

14250  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
14220

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>8207 New Hampshire Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1503 Ladd Street</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) <u>Alice Cecelia Welch</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. O'Beirne</u>		14. MOTHER'S MAIDEN NAME <u>Teresa McDonald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-6153</u>	
17. INFORMANT <u>Alice Welch Mathewson</u>		Address <u>1503 Ladd St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRONCHOPNEUMONIA</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>  </u> to <u>Dec 11, 1961</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Dec 11, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>Dec 11, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <u>345 University Blvd W. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 15 '61</u>	
ADDRESS <u>34 Georgia Avenue Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
VS AIS (4)  
ISM 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14221  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POOLESVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD#2 DICKERSON, MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>WELLS.</u> Last <u>WELLS.</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 30, 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGRICULTURIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRIC. Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES WELLS</u>		14. MOTHER'S MAIDEN NAME <u>EDITH SQUIRES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES 18 DAYS</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1 Dec</u> , 19 <u>61</u> , to <u>6 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>61</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Fawcett</u> M.D.		ADDRESS (Street, city or town, state) <u>Danville</u>	
DATE SIGNED <u>12/5/61</u>		PHYSICIAN'S NAME (Type) <u>P.O. BOYD, MARYLAND</u>	
22a. DATE OF CREMATION, CREMATION, REMOVAL (Specify) <u>12/5/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lee's</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee's Funeral Home 300-46th St N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '61</u>	
ADDRESS <u>Lee's Funeral Home 300-46th St N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. JENRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14252

## CERTIFICATE OF DEATH

14222

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		Item 8 Film G302 12/8/61 Item 2 Film G305 1/18/62		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		STREET ADDRESS <b>2201 Old Georgetown Town</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harriet</b>		First Middle Last <b>Wentworth</b>		4. DATE OF DEATH <b>December 3, 19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/16/1878</b>		9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>	
13. FATHER'S NAME <b>Fairchild</b>		14. MOTHER'S MAIDEN NAME <b>NOT AVAILABLE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT (daughter-in-law) <b>Jeanne Wentworth, 1312 Clifton St., N.W. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> <b>153.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Carcinoma of transverse colon</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> , 19 <b>61</b> to <b>12/3</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>12/3</b> , 19 <b>61</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Wm Y. Marcus</b>		M.D. <b>Wm Y. Marcus</b>		22b. DATE SIGNED <b>12/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm Y. Marcus</b>		22d. ADDRESS <b>10620 Georgia Ave. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Cemetery</b>	
23d. LOCATION (City, town or county) <b>Bethesda, Maryland</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		ADDRESS <b>254 Carroll St., N.W.</b>		25. REC'D BY REGISTRAR <b>DEC 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					



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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14253  
CERTIFICATE OF DEATH  
14223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>83 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Silver Springs</b> d. STREET ADDRESS <b>1905 East-West Highway Apt202</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Luke Matthew WHITE</b>		4. DATE OF DEATH Month Day Year <b>December 31 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 April 1937n</b>
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>
13. FATHER'S NAME <b>David Irvine WHITE</b>		14. MOTHER'S MAIDEN NAME <b>Mary FORBES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>(Wife) Jeanne A. WHITE 1905 E. W. Hwy.</b>	
17. INFORMANT <b>Silver Spring, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 mos.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that **XX** (this hospital) attended the deceased from **Sept. 9, 1961** to **Dec. 31, 1961** that **XX** (we) last saw the deceased alive on **Dec. 31, 1961** and that death occurred at **1:15A**, from the causes and on the date stated above.

22a. SIGNATURE <b>William P. Urschel</b> M.D.	22b. DATE <b>December 31, 1961</b>
22c. PHYSICIAN'S NAME <b>William P. URSHEL LT, MC, USN</b>	22d. ADDRESS <b>U. S. Naval Hospital Bethesda, Md.</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipment</b>	23b. DATE THEREOF <b>1-2-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Orange, N.J.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> <b>R. A. Pumphrey Funeral Home Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>



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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. NAVAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u> d. STREET ADDRESS <u>1 9207 Adelaide Court</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Delbert</u> Middle <u>Swan</u> Last <u>Wicks</u>					4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasion</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1911</u>		9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Providence, R. I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Delbert Samuel Wicks</u>					14. MOTHER'S MAIDEN NAME <u>Anna Arnold</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Name and Address) <u>Elsie R. Wicks 9207 Adelaide Ct., Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial Infarction</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>18 December 1961</u> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>providence, R.I.</u>	
23. FUNERAL DIRECTOR'S NAME (Type) <u>James Lewis</u> ADDRESS <u>W.W. Chambers Funeral Home, Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>James L. Lewis</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14255

## CERTIFICATE OF DEATH

Item 16 Film G305 1/25/62 iwk

14225

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5833 Osceola Court</b>		d. STREET ADDRESS <b>5833 Osceola Court</b>	
3. NAME OF DECEASED (Type or print) <b>Ione Elizabeth Wieker</b>		4. DATE OF DEATH <b>Dec. 20 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1912</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas C. Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Lura M. Matteson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>556-07-9669</b>	
17. INFORMANT <b>John L. Wieker-Husband-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Hypertension</b> DUE TO (c) <b>Metastatic Carcinoma Liver (Primary Rectum)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 year</b> <b>1 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> , to <b>Dec. 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 19, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clifton R. Gruver</b> M.D.		22b. DATE SIGNED <b>12/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clifton R. Gruver</b>		22d. ADDRESS <b>915 19th St. N.W. Wash D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Clifton R. Gruver</b>			

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Croft N Home.</u>				d. STREET ADDRESS <u>5811 - 6th. St N.W.</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mae</u> Middle <u>F</u> Last <u>Wilson</u>				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>19</u> Year <u>19 61.</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 14, 1879</u>			
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ohio</u>					
<b>13. FATHER'S NAME</b> <u>George A Frey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Rudy</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>					
<b>17. INFORMANT</b> <u>Mrs H.E. Matthias-</u>				<b>Address</b> <u>5811 - 6th St. D.C.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Labar Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 d</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Arteriosclerotic Cardio-vascular disease</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June</u> <u>1955</u> <b>to</b> <u>Dec 10</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 8</u> <u>1961</u> , <b>and that death occurred at</b> <u>3 A.M.</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>M. F. OTTMAN</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M. F. OTTMAN</u>				<b>22d. ADDRESS</b> <u>401 Kennedy St NW</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>12-12-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Leeds Crematorium</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington D.C.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee F. Fernal Home - Washington D.C.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 13 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Howard</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14258

14228

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md</b>			
c. LENGTH OF STAY IN 1b <b>1 hr</b>				d. STREET ADDRESS <b>95 E. Wayne Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stella</b>		First		Middle <b>Windish</b>		Last	
4. DATE OF DEATH		Month <b>12</b>		Day <b>30</b>		Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1878</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sharon Park Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Jones</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Everett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-2508A</b>		17. INFORMANT <b>Mr. James F. Lloyd</b>		Address <b>(Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Ventricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Thrombophlebitis leg - Pulmonary embolism with infarction</b> DUE TO (c) <b>1 day</b> <b>1 month</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 29, 1961</b> to <b>Dec 30, 1961</b> , that (I) (we) lost the deceased alive on <b>12/30/1961</b> , and that death occurred at <b>11:50 am</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert R. Hottel</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Robert R. Hottel</b>		22d. ADDRESS <b>1222 Monroe St #15</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 2, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>				ADDRESS <b>254 Carroll St NW. DC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14259

## CERTIFICATE OF DEATH

14229

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring Md.</u> d. STREET ADDRESS <u>Box 271 - Brook Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mearel W.</u>		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>5</u> Year <u>1961</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-14-25</u>		<b>9. AGE</b> (In years last birthday) <u>36</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.																																			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Custodian</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N.I.H.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ya.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>																																											
<b>13. FATHER'S NAME</b> <u>William Wise</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>																																											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes give war/branches of service) <u>W.W.II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>W.W.II</u> <b>17. INFORMANT</b> <u>Wife</u> Address <u>Silver Spring RT. 2 Good Hope Rd.</u>																																											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 151X DUE TO (b) <u>Obstructive jaundice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Recurrent carcinoma of stomach</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 weeks</u> <u>2 yrs</u>																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>																																															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>												<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>												<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Dec 1 1961</u> to <u>Dec 5 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 5 1961</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.																																															
<b>22a. SIGNATURE</b> <u>John J. Curry</u> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <u>12/5/61</u>																																									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>						<b>22d. ADDRESS</b> <u>10620 Germain Ave</u>																																									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/9/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sandy Spring, Md.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Sandy Spring, Md.</u>																																			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u>						<b>ADDRESS</b> <u>Rockville, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 11 '61</u>						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>																													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and is hereby filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

only writing, M.

only writing, M.

12/31

only

only writing, M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14250 Items 3 & 10b, Film 0306 2/5/62 iwk											
14230											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5732 2nd St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Laurie</u> Last <u>Wyke (Gilchrist)</u>						4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-30-97</u>		9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>N.S.A. (National Security Agency)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Daniel N. Gilchrist</u>						14. MOTHER'S MAIDEN NAME <u>Betsy Ann Wigal</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>246-12-3174</u>		17. INFORMANT <u>Mrs Betty Everley 4804</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157 X</u> DUE TO <u>Myocardial weakness, ECG changes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Exacerbation of the Diabetes</u> (c) <u>Insult</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/22/61</u> , 19 <u>61</u> to <u>12/26/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles Wolohon</u> M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Wolohon</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>12/28/1961</u>		<u>St Lincoln</u>		<u>Colmer Manor, Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Francis Hasch Sons Hyattsville, Md</u> ADDRESS						25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Walter S. Thomas</u>			

M

1920

1920

RECEIVED

Post Office

Washington

July 1, 1920

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

Special Agent in Charge

U. S. Department of Justice

Washington, D. C.

Washington

July 1, 1920

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

Special Agent in Charge

U. S. Department of Justice

Washington, D. C.

Clark

Post Office

Washington

July 1, 1920

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

Special Agent in Charge

U. S. Department of Justice

Washington, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14261

## CERTIFICATE OF DEATH

14231

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN 1b <b>19 da</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wheaton Nursing Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>478-3</b> d. STREET ADDRESS <b>742 Van Buren St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Naomi</b> Middle <b>R.</b> Last <b>YOPPS</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1961</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 7, 1881</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Garner</b>			14. MOTHER'S MAIDEN NAME <b>Louisa Weaver</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>no</b>		
17. INFORMANT <b>Otto E. Yopps</b>			Address <b>742 VanBuren St. N.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Cardiac failure</b> DUE TO <b>Cardio-Vascular-Renal Disease Sev. yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>20 days</b> DUE TO <b>20 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Senility - Arteriosclerosis</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Nov. 1, 1961</b> to <b>Dec. 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred <b>4:40 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lynwood Heiges</b>		M.D. <b>LYNWOOD HEIGES, MD, FACA</b>		22b. DATE SIGNED <b>12/31/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>6940 Piney Branch Road N.W. Washington 12, D.C. Ft. Lincoln Cemetery</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1/2/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The F.D. Jones Co.</b>		ADDRESS <b>2901 14th St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>					



13801

D.C.

Washington

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Van Eaton St. W.

Washington D.C.

YCPB

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Washington D.C.

Washington D.C.

Lowell Avenue

Lowell Avenue

1000 N. York St. Washington D.C.

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Central Branch

Central Branch

LYNWOOD HIGGS, MD. FACA

6940 Piney Branch Road, N.W.

Washington, D.C.

Washington, D.C.